Kansas
Department for Aging and Disability Services

SHICK Initial Counselor Training Course 1 Introduction to Original Medicare – Parts A & B

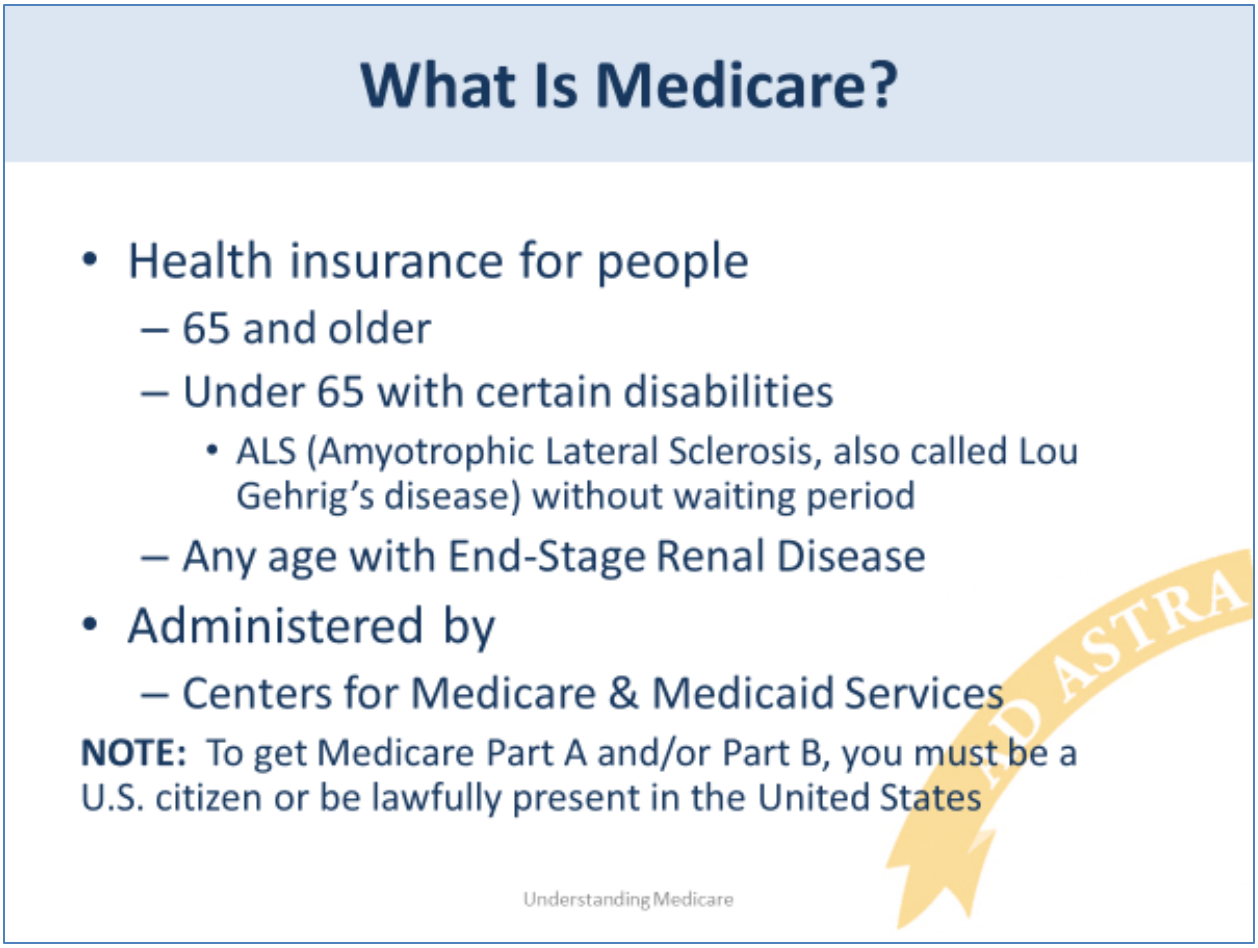
SHICK Senior Health Insurance Counseling for Kansas

Online Pre-Training

Rev. 2/2019

Pre-Training Objectives

- Course 1 provides basic training in Medicare Part A, Part B, Preventive Benefits, Medicare for people with disabilities, and Medicare for people with ESRD.
- You should thoroughly study the course including the notes. You will need to pass an exam after this course before continuing to Course 2.



Medicare currently provides health insurance coverage for 57.7 million U.S. citizens. That's approximately 1 in every 6 Americans.

- Medicare is health insurance for generally 3 groups of people:

Those who are 65 and older

People under 65 with certain disabilities who've been entitled to Social Security disability benefits for 24 months—includes ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), without a waiting period

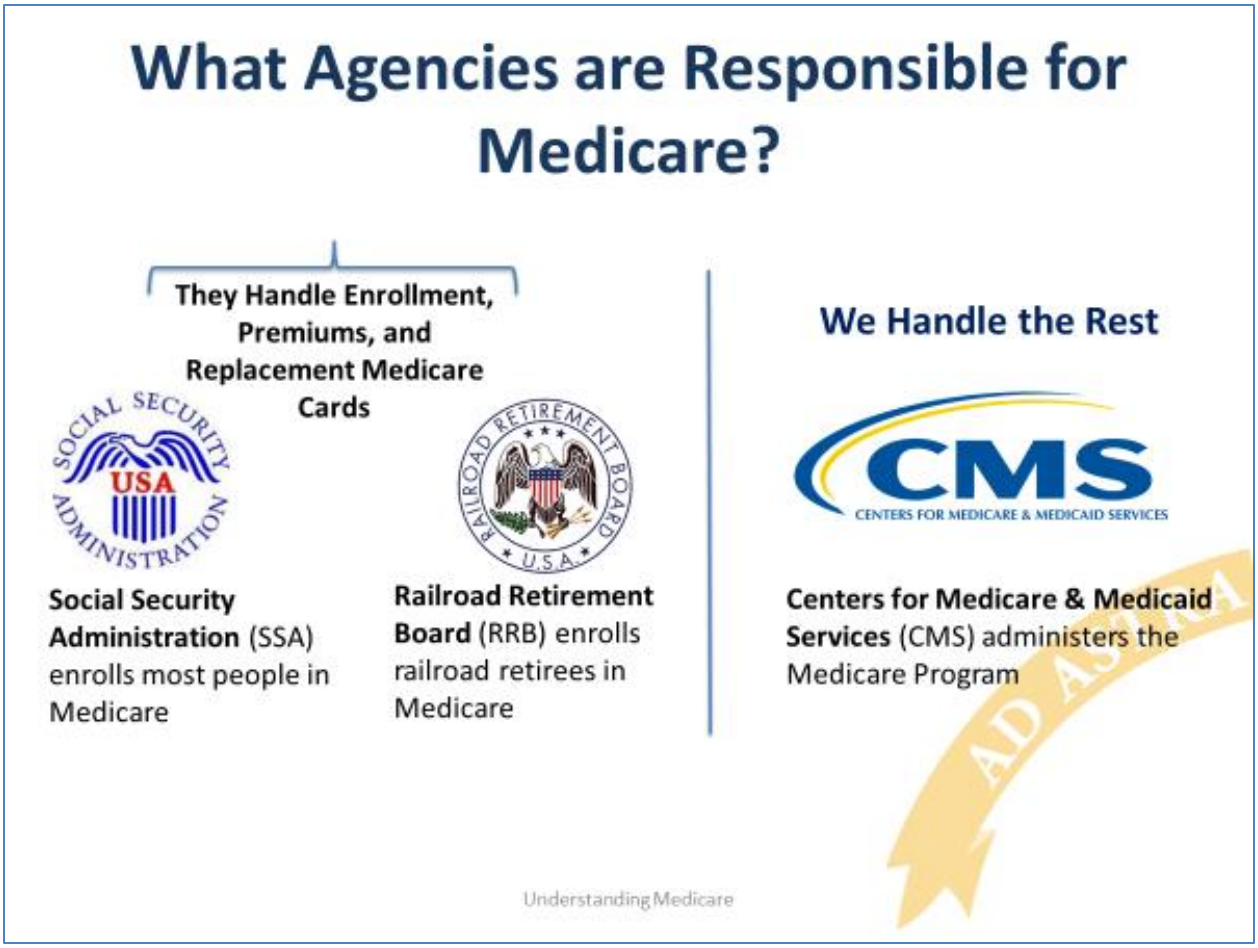
People of any age who have End-Stage Renal Disease (ESRD), which is permanent kidney failure that requires a regular course of dialysis or a kidney transplant

The Centers for Medicare & Medicaid Services administers the Medicare Program.

NOTE: To get Part A and/or Part B, you must be a U.S. citizen or be lawfully present* in the United States. If you live in Puerto Rico, you must actively enroll in Part B.

*Lawfully present means you're in the U.S. legally, and includes non–U.S. citizens who have permission to live and/or work in the U.S. and have been residing in the United States for 5 continuous years prior to the month of filing an application for Medicare.

Resource: "Medicare & You" handbook (Medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf)



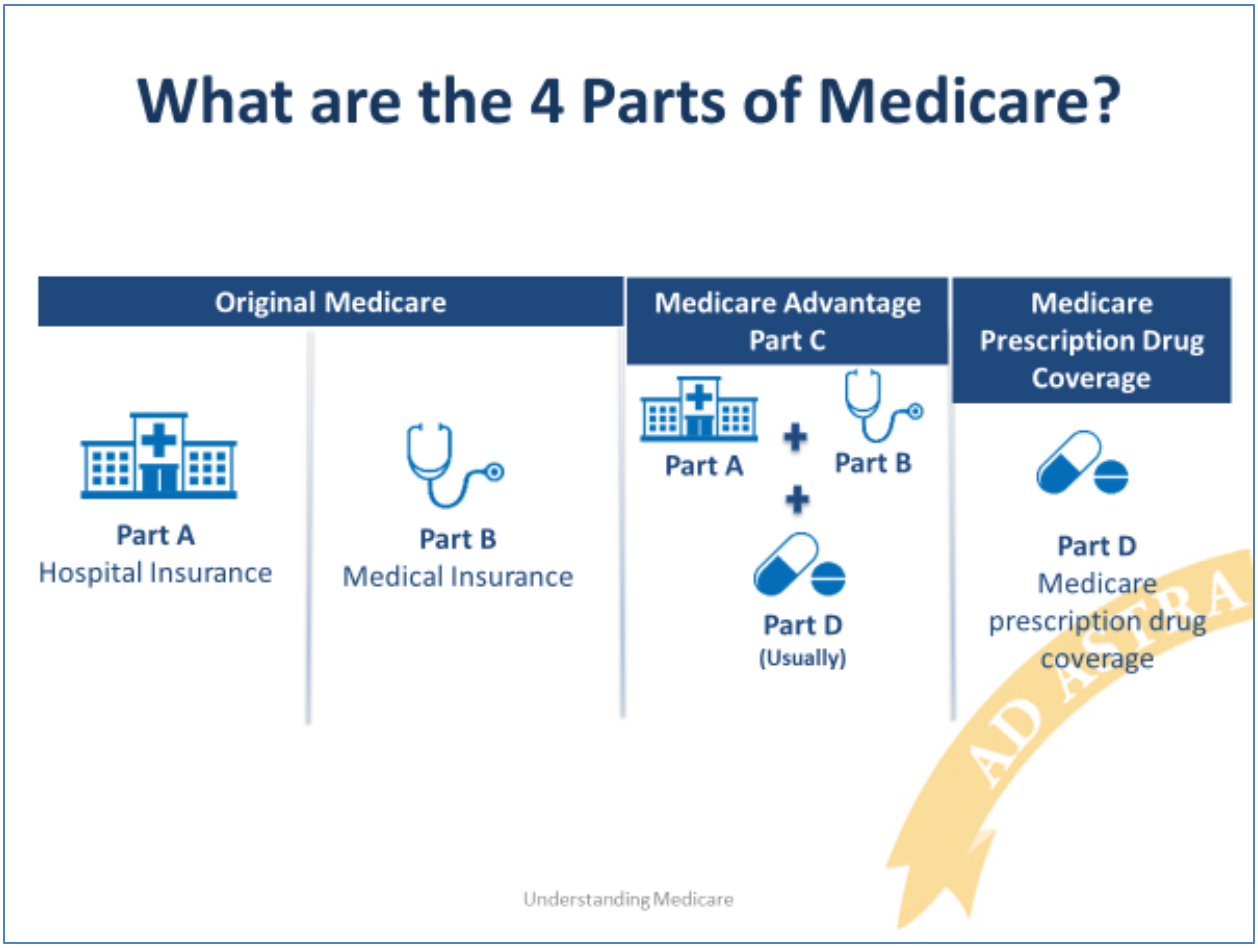
The Social Security Administration (SSA) is responsible for enrolling most people in Medicare.

The Railroad Retirement Board (RRB) is responsible for enrolling railroad retirees in Medicare.

SSA and RRB also collect premiums and determine the amounts of the Part A (if you must pay for it) and Part B premiums. They also handle replacement Medicare cards.

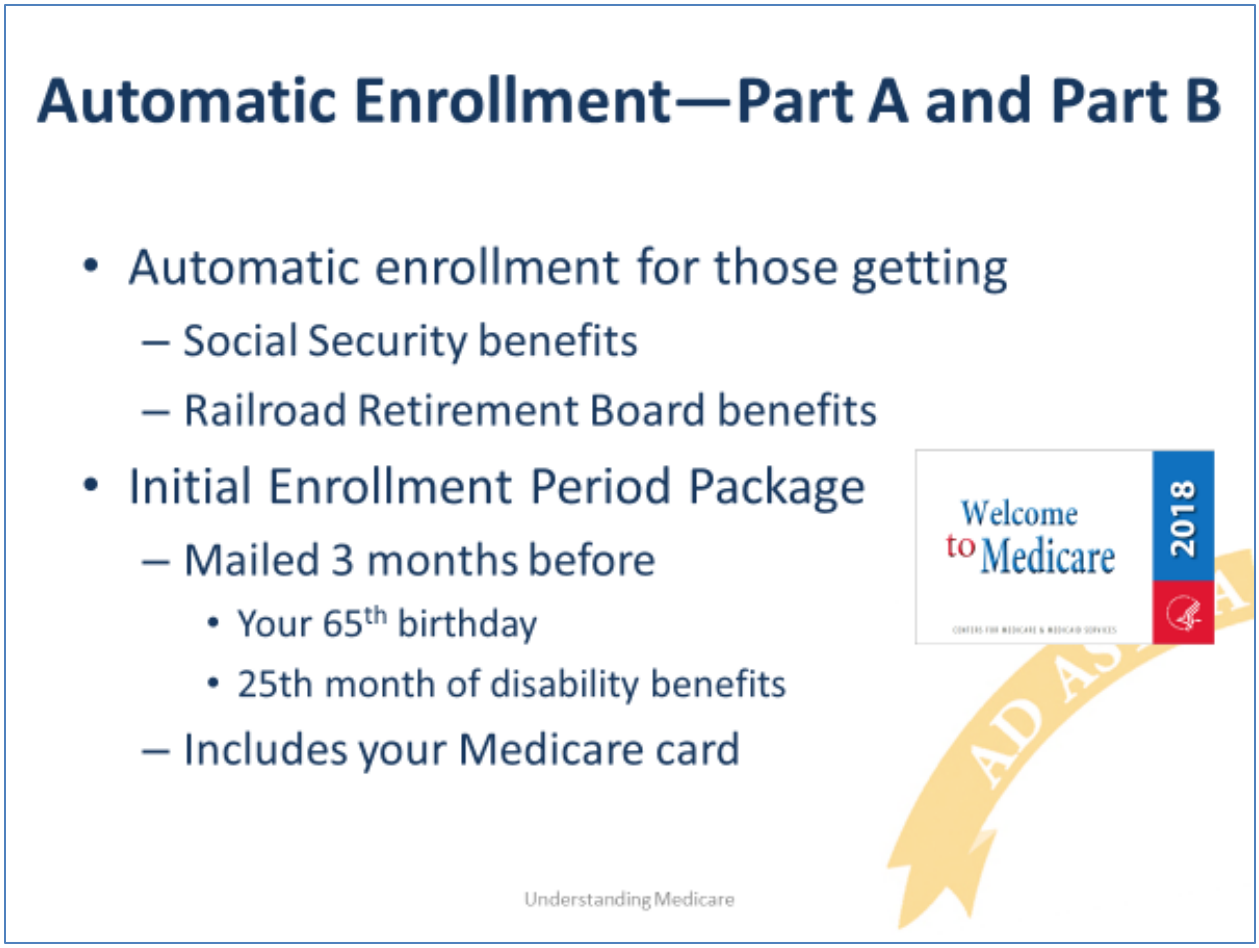
Medicare is administered by the Centers for Medicare & Medicaid Services (CMS).

If you retired from federal service, contact the Office of Personnel Management regarding your premiums.



Medicare covers many types of services, and you have options for how to get your Medicare coverage. Medicare has 4 parts:

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.
- **Part B (Medical Insurance)** helps cover medically necessary services like doctor's visits and outpatient care. Part B also covers many preventive services (including screening tests and shots), diagnostic tests, some therapies, and durable medical equipment like wheelchairs and walkers. Together, Part A and Part B are also referred to as "Original Medicare."
- **Part C (Medicare Advantage [MA])** is another way to get your Medicare benefits. It combines Part A and Part B, and sometimes Part D (prescription drug coverage). MA Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services than Original Medicare.
- **Part D (Medicare Prescription Drug Coverage)** helps pay for outpatient prescription drugs. Part D may help lower your prescription drug costs and protect you against higher costs in the future.



If you're already getting Social Security benefits (for example, getting early retirement at least 4 months before you turn 65), you'll be automatically enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment Period package, which includes your Medicare card and other information, about 3 months before you turn 65 (coverage begins the first day of the month you turn 65), or 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits).

If you're not getting retirement benefits from Social Security or the Railroad Retirement Board (RRB), you must sign up to get Medicare (see page 9).

NOTE: If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65, or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it. If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Contact your local Social Security office or the RRB for more information.

"Welcome to Medicare," CMS Product No. 11095, is pictured on this page. It's part of the Initial Enrollment Period package. Visit https://www.medicare.gov/Pubs/pdf/11095-Welcome-to-Medicare.pdf.

When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care services. The Medicare card shows the type of Medicare coverage (Part A and/or Part B) you have and the date the coverage started. Your card may look slightly different from this one; it's still valid.

The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals indicate which Social Security record your Medicare is based on. You should contact Social Security (or the Railroad Retirement Board if you receive railroad retirement benefits) if any information on the card is incorrect.

The Medicare Access and CHIP Reauthorization Act of 2015 requires us to remove Social Security Numbers from all Medicare cards. The work is underway and more information will be available later. You can visit, CMS.gov/medicare/ssnri/ for information about this initiative.

NOTE: Social Security has an online service that lets you get a replacement Medicare card if your old one is lost or needs to be replaced. To create your account and learn more about "my social security" accounts, visit SSA.gov/myaccount.

If you get your Medicare card in your Initial Enrollment Period package and keep it, you keep Part B and will pay the Part B premium (unless Medicaid pays your premium). If you don't want Part B, and decide to enroll later, you'll likely pay a late enrollment penalty. If you don't want Part B, follow the directions on the back of the card, and return it. We'll describe reasons why you might want to delay taking Part B later in this presentation. If you choose a Medicare health plan, your plan will likely give you a card to use when you get health care services and supplies.

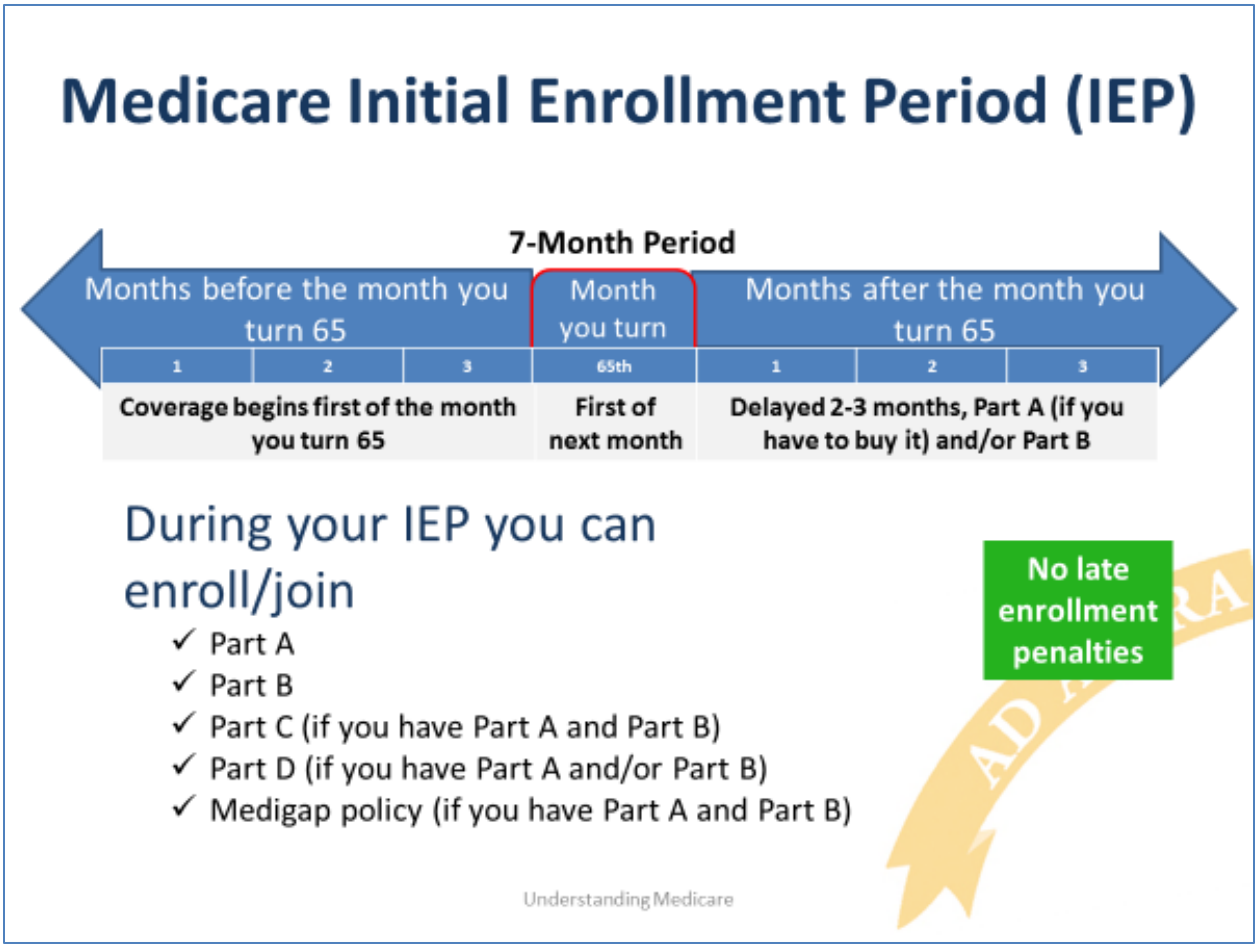
If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits at least 4 months before you turn 65 (for instance, because you're still working), you'll need to sign up for Part A and Part B (even if you're eligible to get Part A premium free). You should contact Social Security 3 months before you turn 65. If you worked for a railroad, contact the RRB to sign up. You don't have to be retired to get Medicare.

Full retirement age (also called "normal retirement age") had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959.

The 1983 Social Security Amendments included a provision for raising the full retirement age beginning with people born in 1938 or later. Congress cited improvements in the health of older people and increases in average life expectancy as primary reasons for increasing the normal retirement age.

For more information or to calculate your age for collecting full Social Security retirement benefits, visit SSA.gov/retirement/ageincrease.htm.

NOTE: Although the age to receive full Social Security retirement benefits is increasing, Medicare benefit eligibility due to age still begins at 65.



Your first opportunity to enroll in Medicare is during your **Initial Enrollment Period (IEP)**, which lasts 7 months. Your coverage starts based on when you enroll. If you enroll during the first 3 months of your IEP (the 3 months before the month you turn 65), your coverage will begin the first day of the month you turn 65.

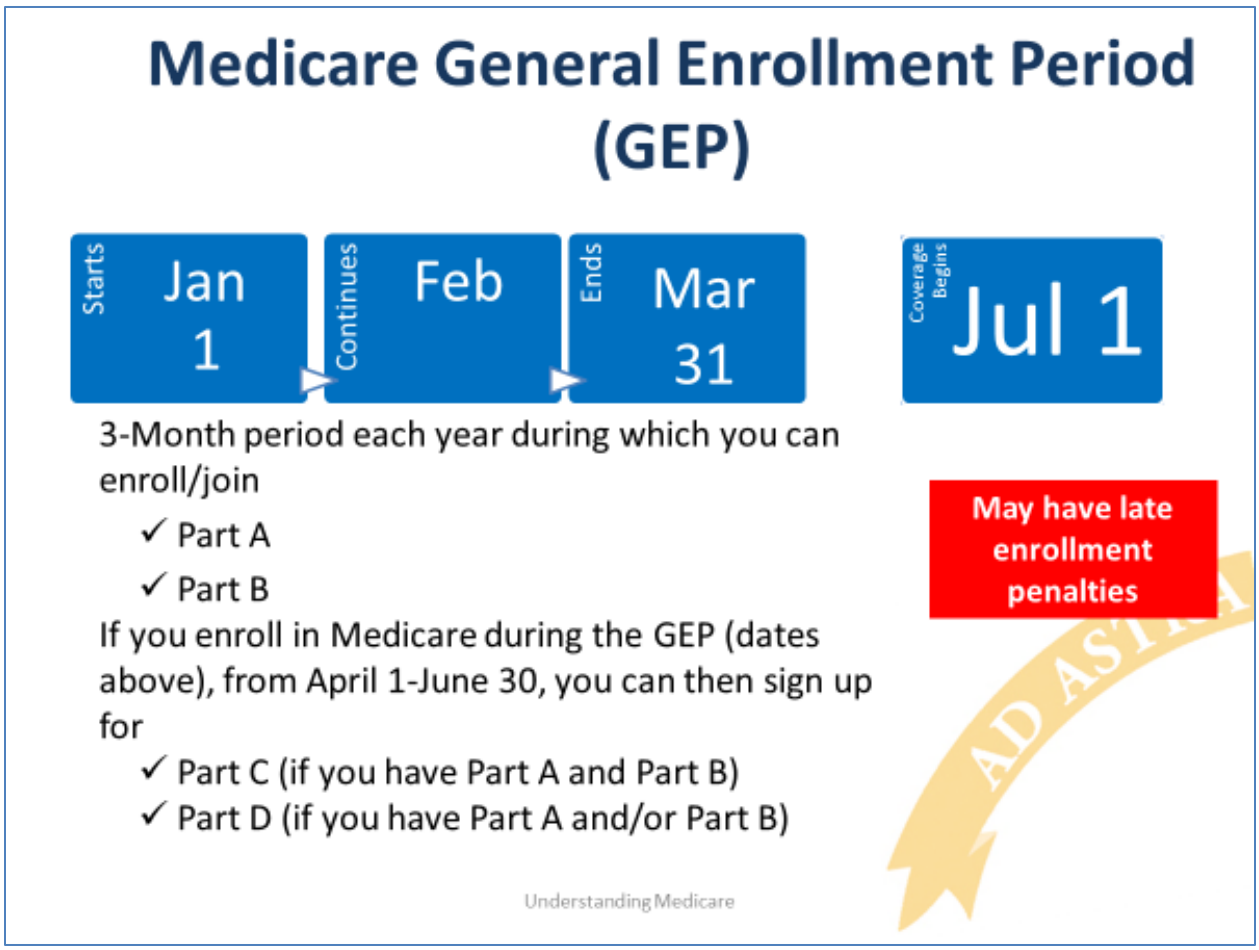
If you enroll in Part A (if you have to buy it) and/or Part B

- The month you turn 65, your coverage starts one month after you sign up
- One month after you turn 65, your coverage starts 2 months after you sign up
- 2 months after you turn 65, your coverage starts 3 months after you sign up
- 3 months after you turn 65, your coverage starts 3 months after you sign up
- During the January 1-March 31 General Enrollment Period, your coverage starts on July 1

If you're eligible for premium-free Part A, you can enroll in Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you're not eligible for premium-free Part A, you can only enroll in Part A during your IEP or during the limited Part B enrollment periods.

If you don't enroll in Part B (or Part A if you have to buy it) during your IEP, you may have to pay a penalty. For Part B, it's a lifetime penalty.

NOTE: For an individual whose 65th birthday is on the first day of the month, Part A coverage begins on the first day of the month preceding their birth month. For example, if an individual's birthday is on December 1, Part A begins on November 1.

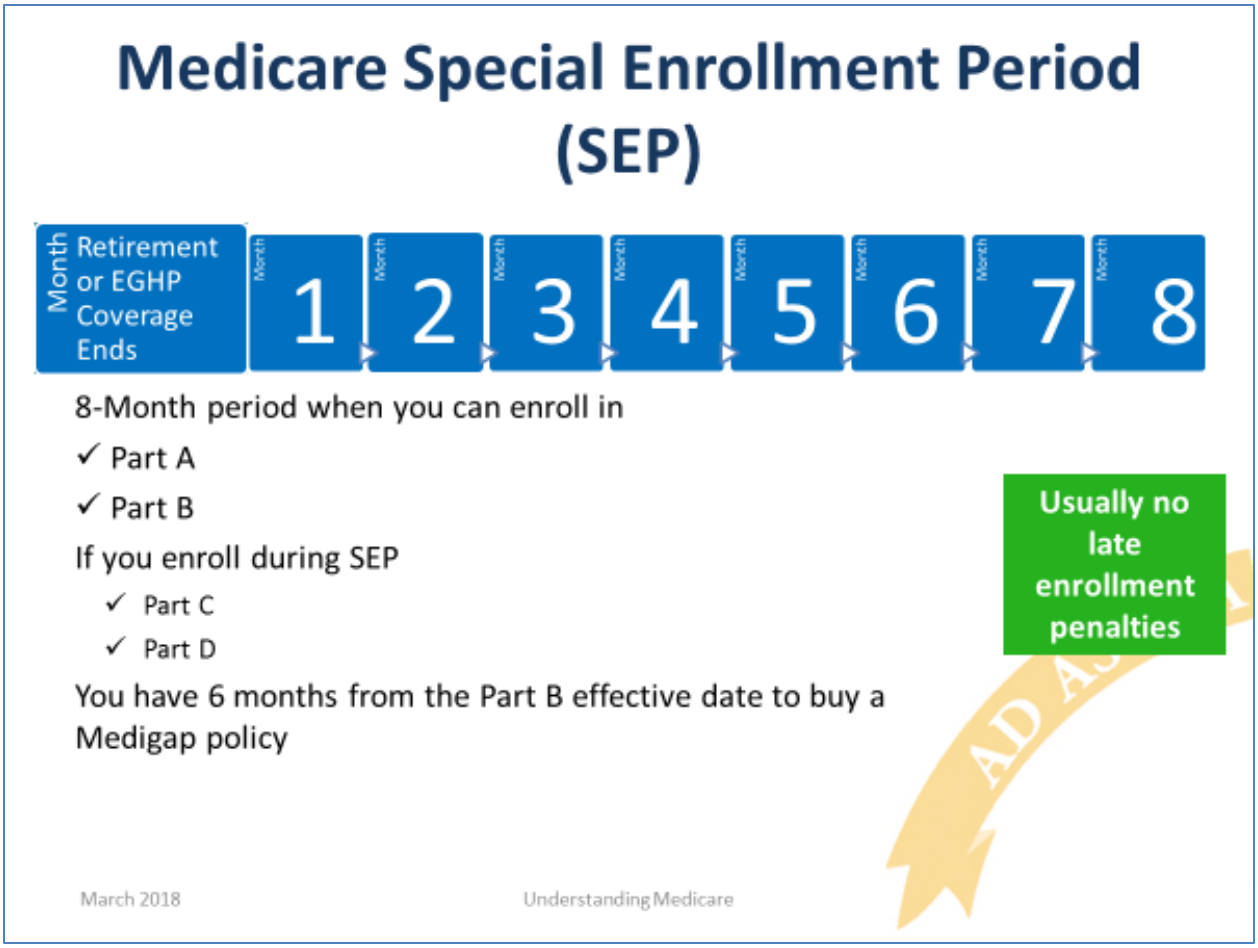


If you didn't sign up for Part B (or premium Part A) during your Initial Enrollment Period (IEP), you can enroll during the General Enrollment Period (GEP).

The GEP occurs January 1 through March 31 each year. If you enroll in the GEP, your coverage will begin July 1.

If you aren't eligible for premium-free Part A and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Generally, if you don't take Part B when you're first eligible and more than 12 months have passed since you turned 65, you'll likely have to pay a penalty that's added to your monthly Part B premium. The Part B penalty is 10% for each full 12-month period you could've had Part B, but didn't sign up for it. In most cases you'll have to pay this penalty for as long as you have Part B.



If you or your spouse are still working, and you didn't sign up for Part B (or Part A (if you had to buy it)) during your **Initial Enrollment Period** (IEP), you may be able to enroll during the **Special Enrollment Period (SEP)**. The SEP allows you to enroll after your IEP and not wait for the GEP. If eligible, you won't have to pay a penalty, but this SEP is limited.

To be eligible, you must have group health plan coverage based on active, current employment for all the months you were eligible to enroll in Part B, but didn't. If you're 65 or older, you must get this employer-sponsored coverage based on your or your spouse's current employment. If you have Medicare based on disability, you can also have employer-sponsored coverage based on a member's current employment. It's important to note that COBRA, retiree coverage, long-term workers' compensation or Veterans Affairs coverage isn't considered active, current employment.

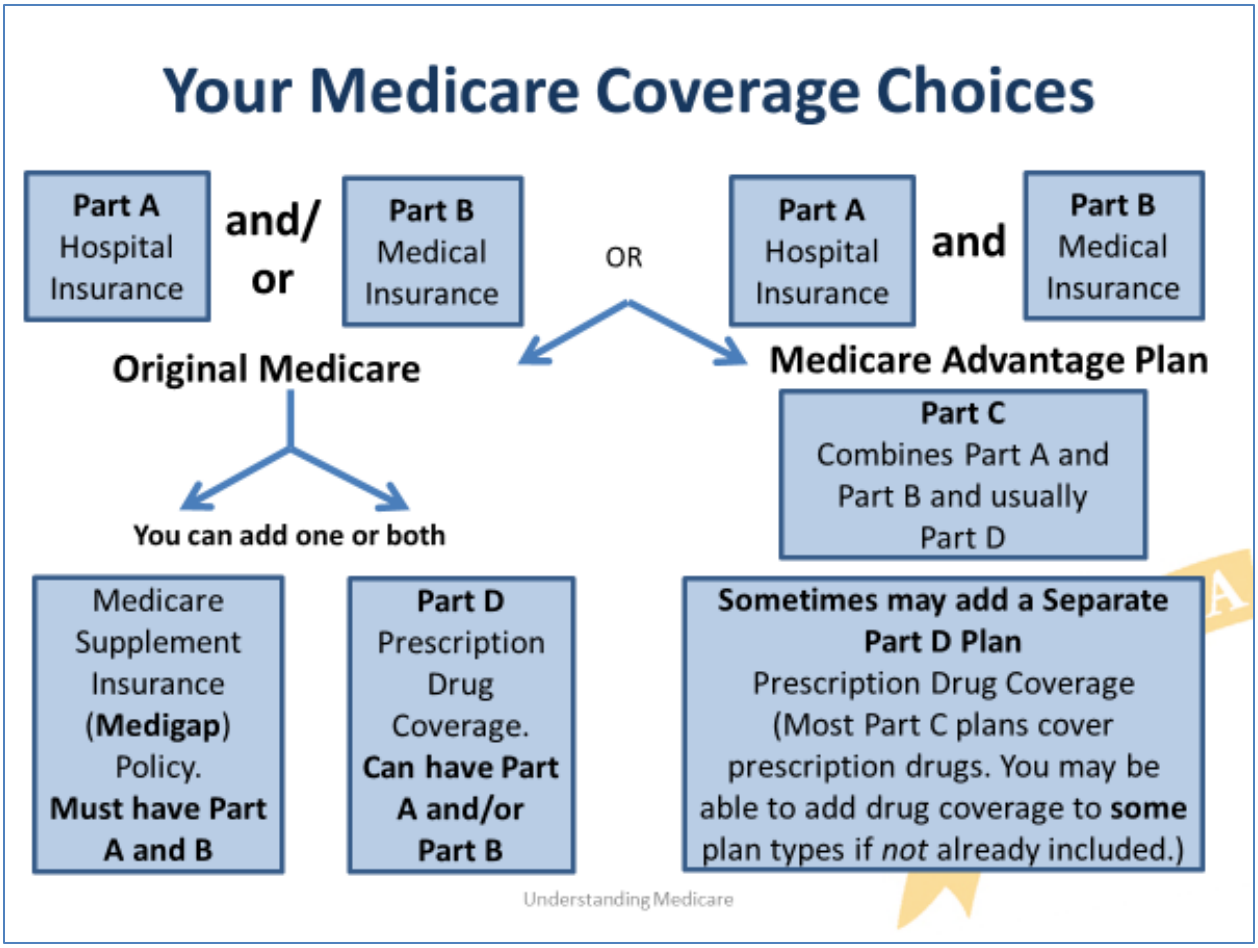
You have an 8-month SEP to sign up for Part A and/or Part B that starts at one of these times (whichever happens first):

- The month after the employment ends
- The month after group health plan insurance based on current employment ends

For information on joining a Part C or Part D plan see Course 2.

If you delay Part B and get it during your SEP, you start your Medigap Open Enrollment Period. You can buy a Medigap policy during 6 months after the Medicare Part B effective date.

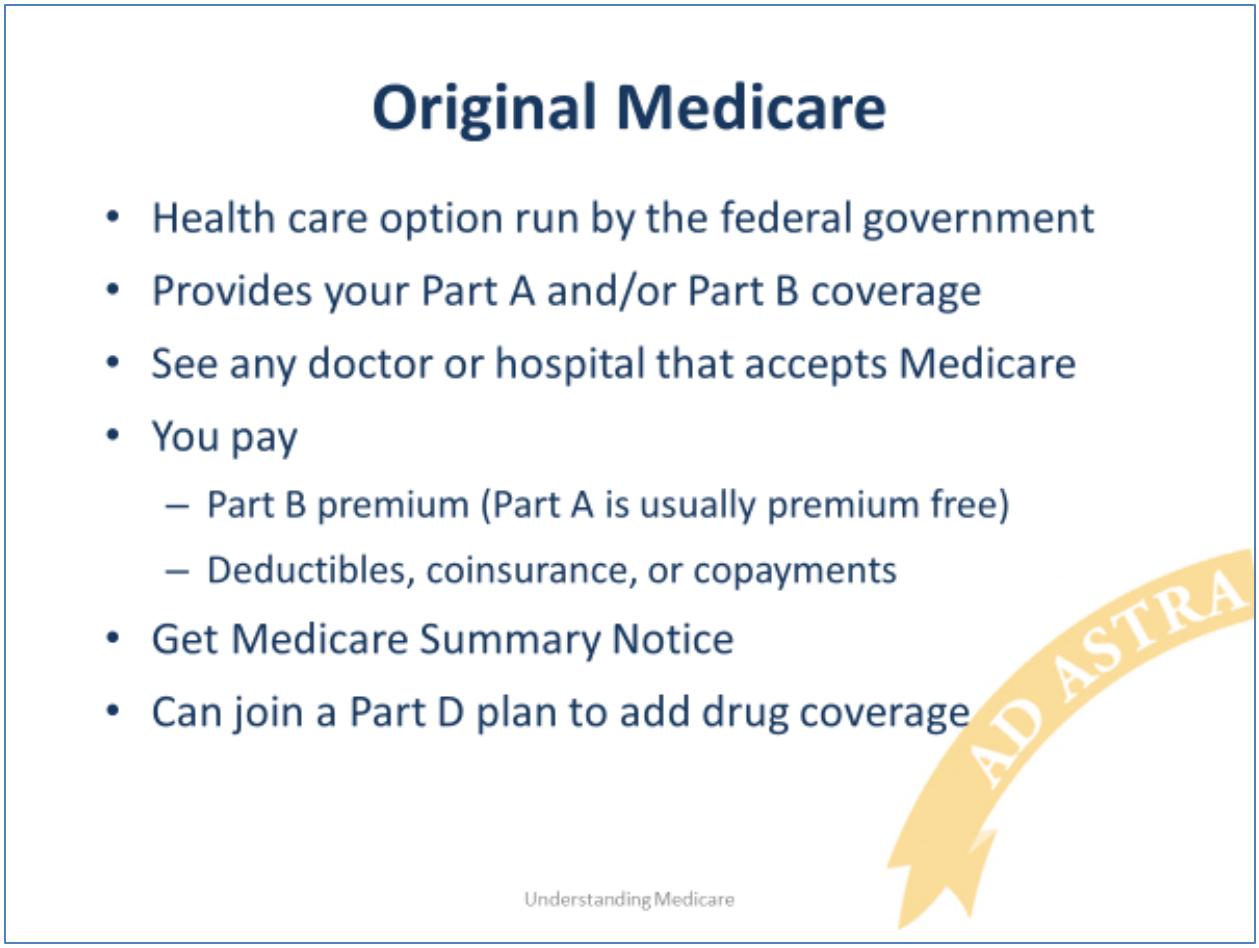
If you don't enroll within the 8 months, you'll have to wait until the next GEP to enroll, you'll have a gap in your coverage, and you may have to pay a penalty.



There are 2 main ways to get your Medicare coverage, Original Medicare, or Medicare Advantage (MA) Plans. You can decide which way to get your coverage.

1. Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). You can choose to buy a Medigap Policy to help cover some costs not covered by Original Medicare. You can also choose to buy Medicare prescription drug coverage (Part D) from a Medicare Prescription Drug Plan (PDP).
2. MA Plans (Part C), like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), cover Part A and Part B services and supplies. They also may include Medicare prescription drug coverage (MA-PD). You can add a Medicare Prescription Drug Plan to a Medicare Private Fee-for-Service Plan or Cost Plan if they don't provide Part D coverage, and you can add it to a Medicare Medical Savings Account (MSA) Plans. You can't add a Part D plan to a Medicare HMO or PPO plan without drug coverage.

Medigap policies don't work with these plans. If you join a Medicare Advantage Plan, you can't use a Medicare Supplement Insurance (Medigap) Policy to pay for out-of-pocket costs while you are enrolled in an MA Plan.

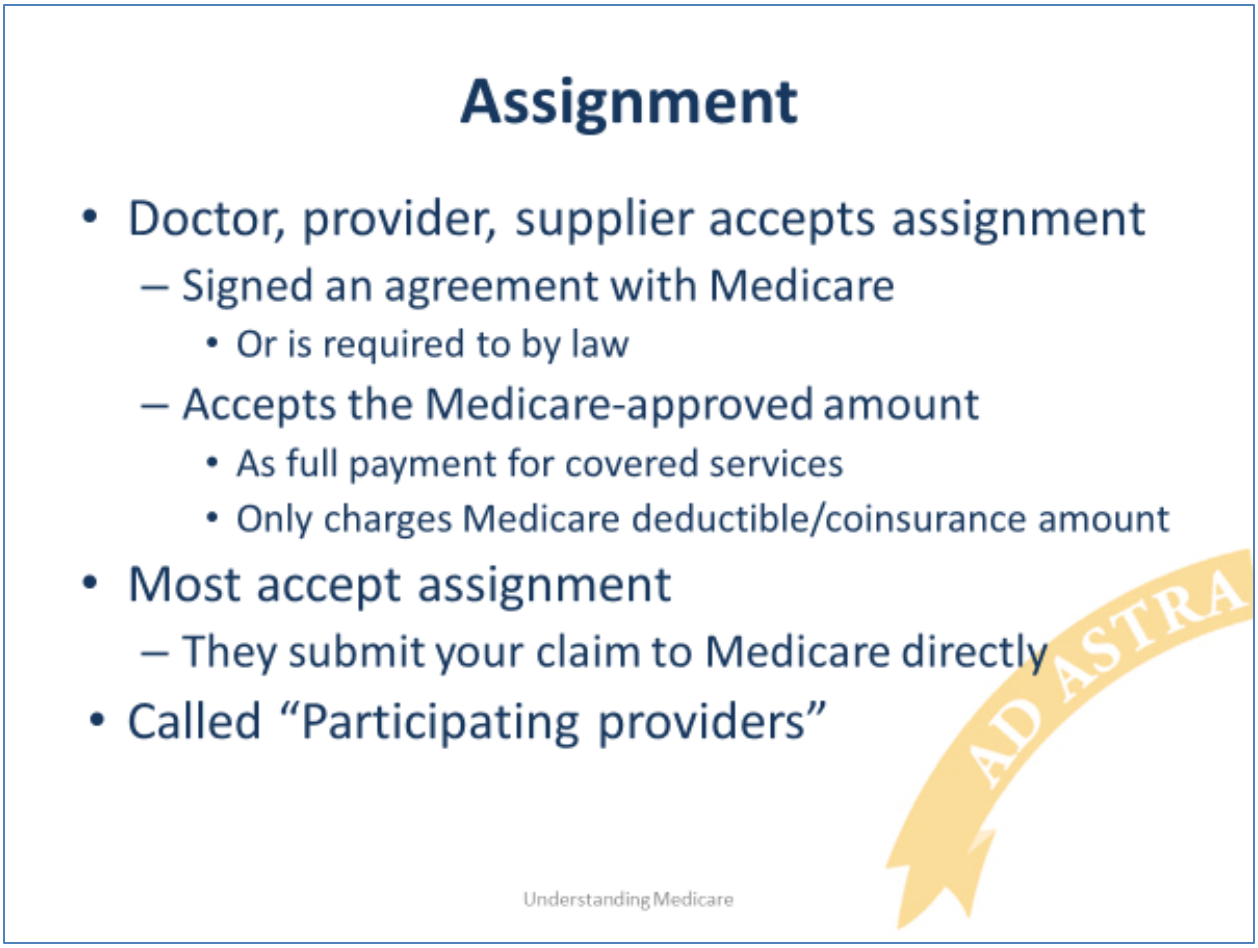


Original Medicare is one of the coverage choices in the Medicare Program. You'll be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare health plan. Original Medicare is a fee-for-service program that's managed by the federal government. With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

If you have Medicare Part A, you get all medically necessary Part A–covered services. If you have Medicare Part B, you get all medically necessary Part B–covered services. As we mentioned earlier, Part A is premium-free for most people. For Medicare Part B you pay a monthly premium. The standard Medicare Part B monthly premium for those not "held harmless" is $134 in 2018.

In Original Medicare, you also pay deductibles, coinsurance, or copayments. After you receive health care services, you'll get a notice in the mail, called a "Medicare Summary Notice" (MSN), that lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There's information on the MSN about how to ask for an appeal.

If you're in Original Medicare, you can also join a Medicare Prescription Drug Plan (Part D) to add drug coverage.



Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. Participating providers have signed an agreement to accept assignment for all Medicare-covered services.

Here's what happens if your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less
- They agree to charge you only the Medicare deductible and coinsurance amount, and usually wait for Medicare to pay its share before asking you to pay your share
- They must submit your claim directly to Medicare and can't charge you for submitting the claim

In some cases, doctors, providers, and suppliers must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.

"Non-participating" providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. If your doctor, provider, or supplier doesn't accept assignment:

- You might have to pay the entire charge at the time of service. Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. In some cases, you might have to submit your own claim to Medicare using form CMS-1490S to get paid back. Visit Medicare.gov/forms-help-and-resources/forms/medicare-forms.html for the form and instructions.
- They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge" or "excess charge." The provider can only charge you up to 15% over the amount that non-participating providers are paid. Non-participating providers are paid 95% of the fee schedule amount. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

To find out if your doctors, suppliers, and other health care providers accept assignment or participate in Medicare, visit Medicare.gov/physician or Medicare.gov/supplier.

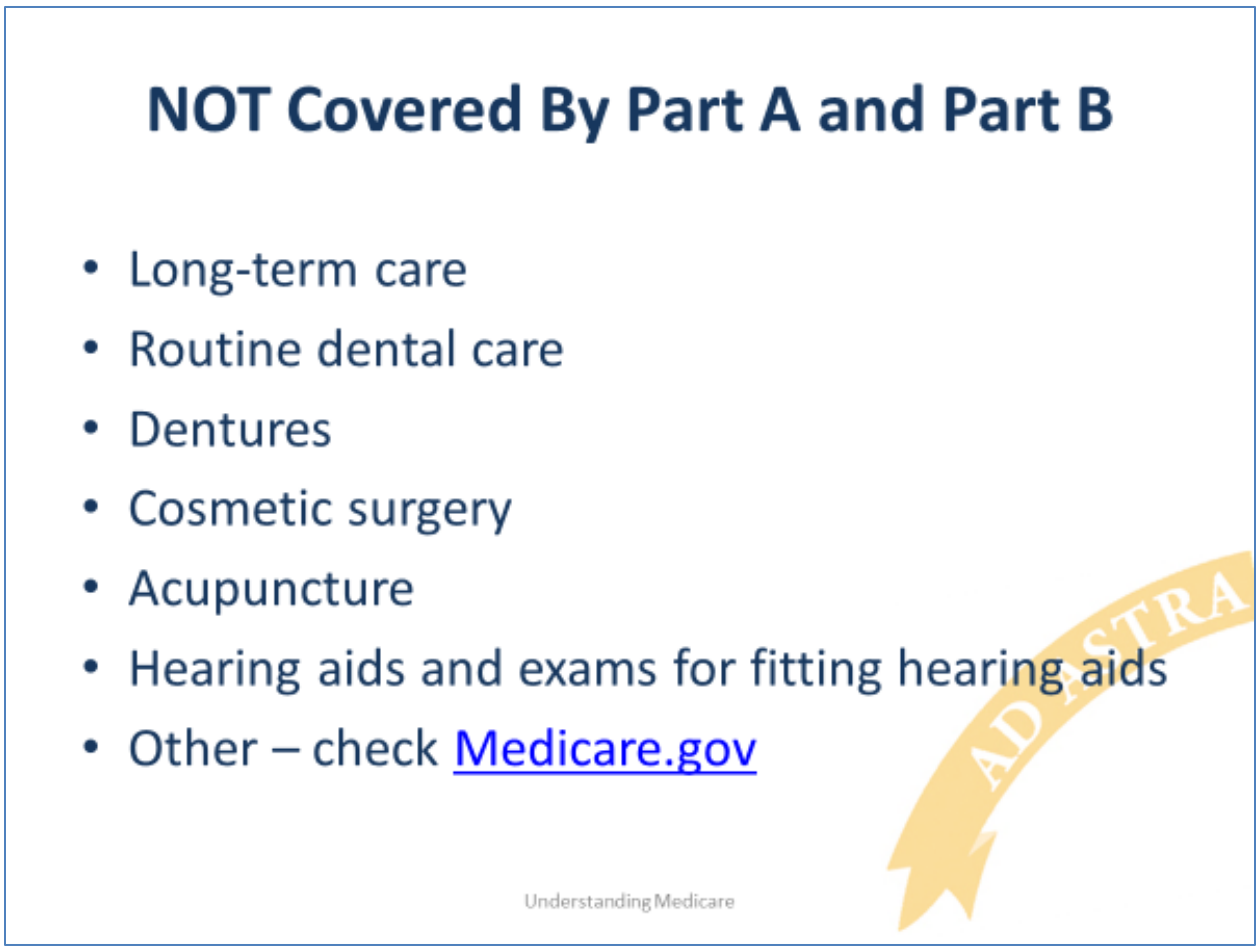
If you get your Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare Program, they're supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Ambulance suppliers must accept assignment. For more information on ambulance coverage, visit Medicare.gov/coverage/ambulance-services.html.

A private contract is an agreement between you and a doctor who has decided not to furnish services through the Medicare Program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medicare Supplement Insurance (Medigap) Policies won't pay for the services you get from the doctor with whom you have a private contract. You can't be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor

- No Medicare payment will be made for the services you get from the doctor.
- Your Medigap policy, if you have one, won't pay anything for the service.
- You'll have to pay whatever this doctor or provider charges you. (The Medicare limiting charge won't apply.)
- Other Medicare plans won't pay for the services.
- No claim should be submitted, and Medicare won't pay if one is submitted.
- Many other insurance plans won't pay for the service either.
- The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare.
- Providers who do not accept Medicare payment at all are called "Opt-out" providers.

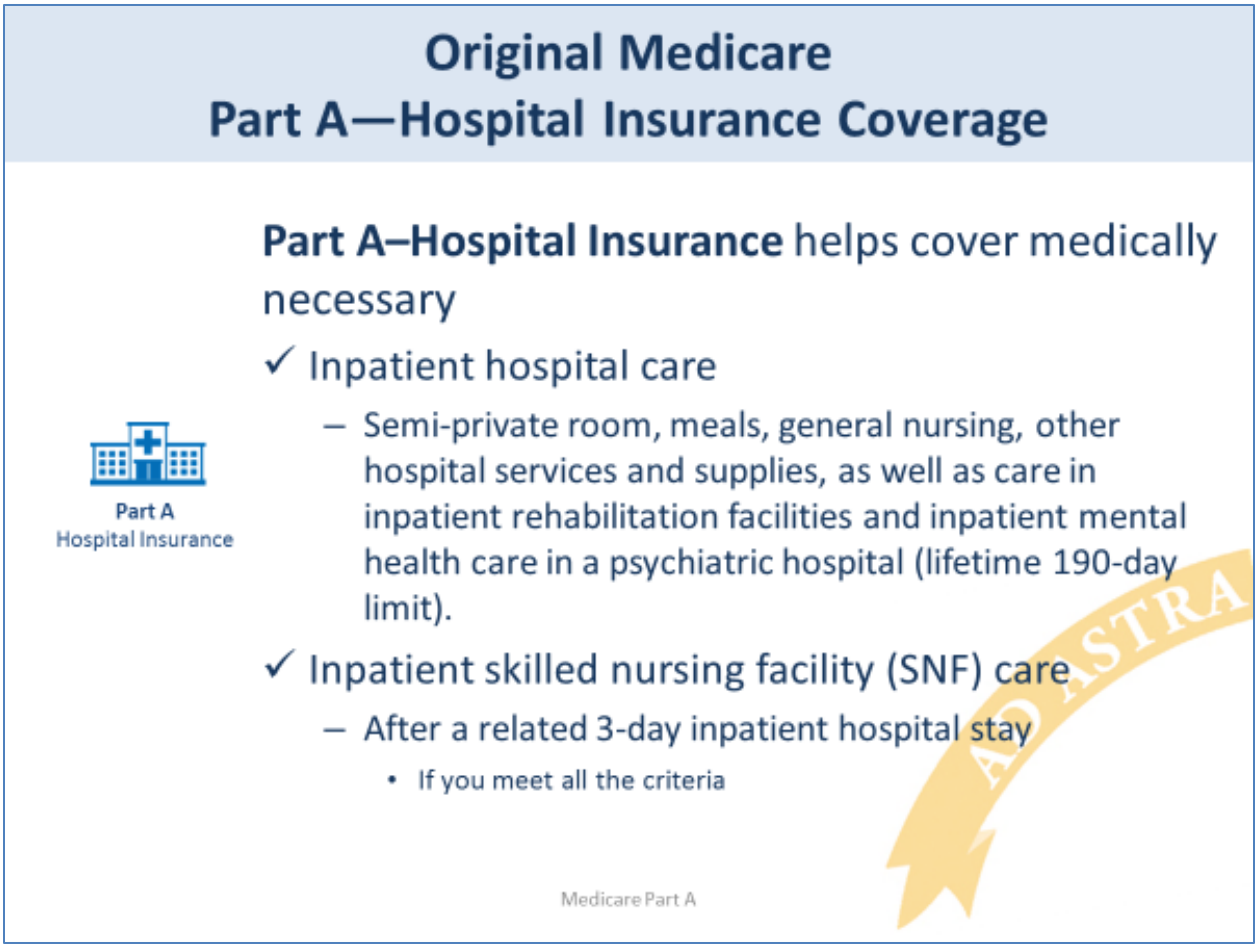


Medicare Part A and Part B don't cover everything. If you need certain services that Medicare doesn't cover, you'll have to pay out-of-pocket unless you have other insurance to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.

Medicare doesn't cover long-term care. Long-term care includes medical and nonmedical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home.

Items and services that Medicare doesn't cover include, but aren't limited to, other, routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

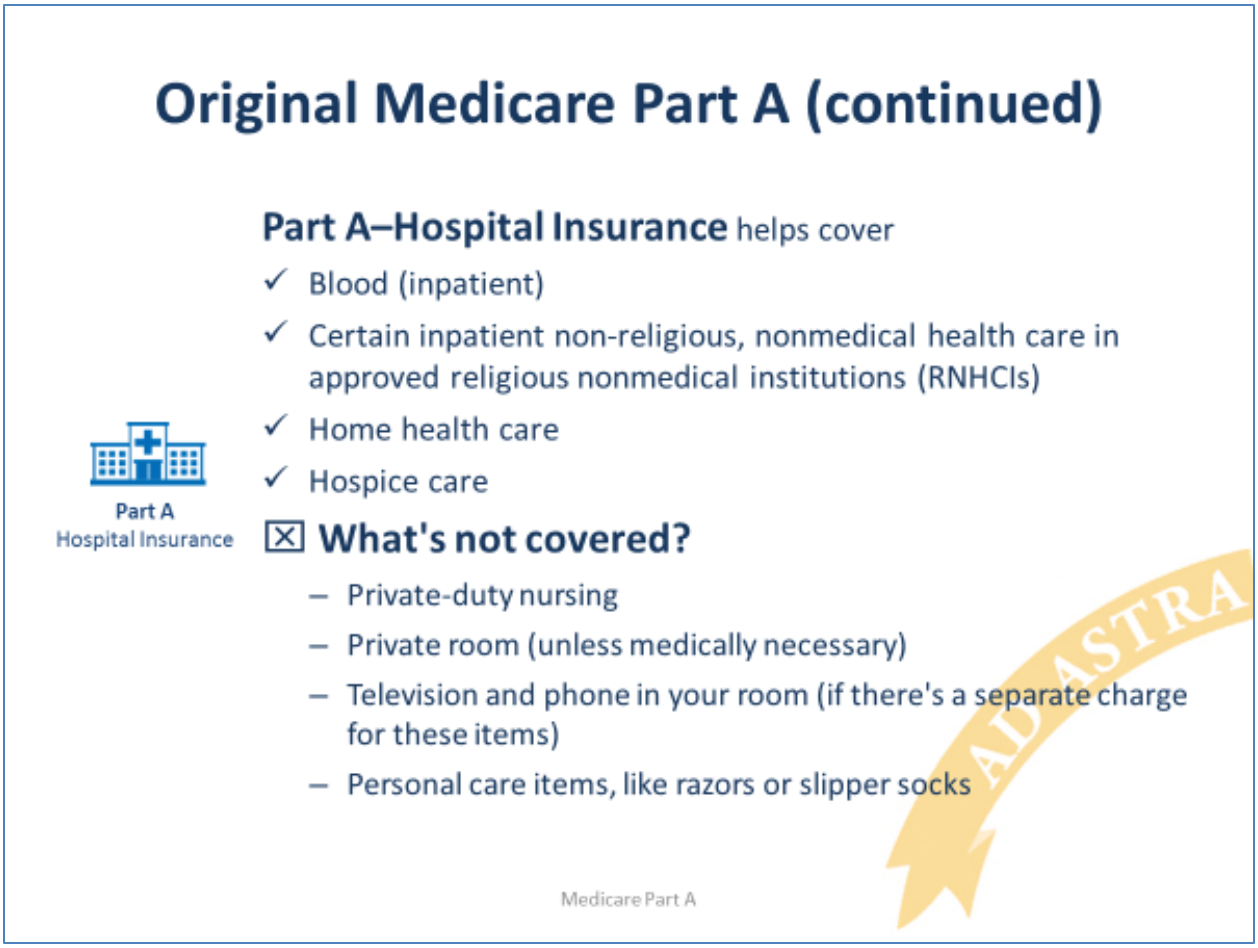
For more information about what isn't covered by Medicare, visit Medicare.gov/what-medicare-covers/not-covered/item-and-services-not-covered-by-part-a-and-b.html.



Medicare Part A (Hospital Insurance) helps cover medically necessary inpatient services.

- Hospital inpatient care–Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit).
- Inpatient skilled nursing facility (SNF) care (not custodial or long-term care) under certain conditions.
- Blood—In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker.
- Home health care—A doctor, or certain health care providers who work with the doctor, must see you face-to-face to certify that you need home health services. You must be homebound, which means that leaving home is a major effort.
- Hospice care—Your doctor must certify that you're expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; as well as services Medicare usually doesn't cover, such as grief counseling.

NOTE: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the United States. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated.

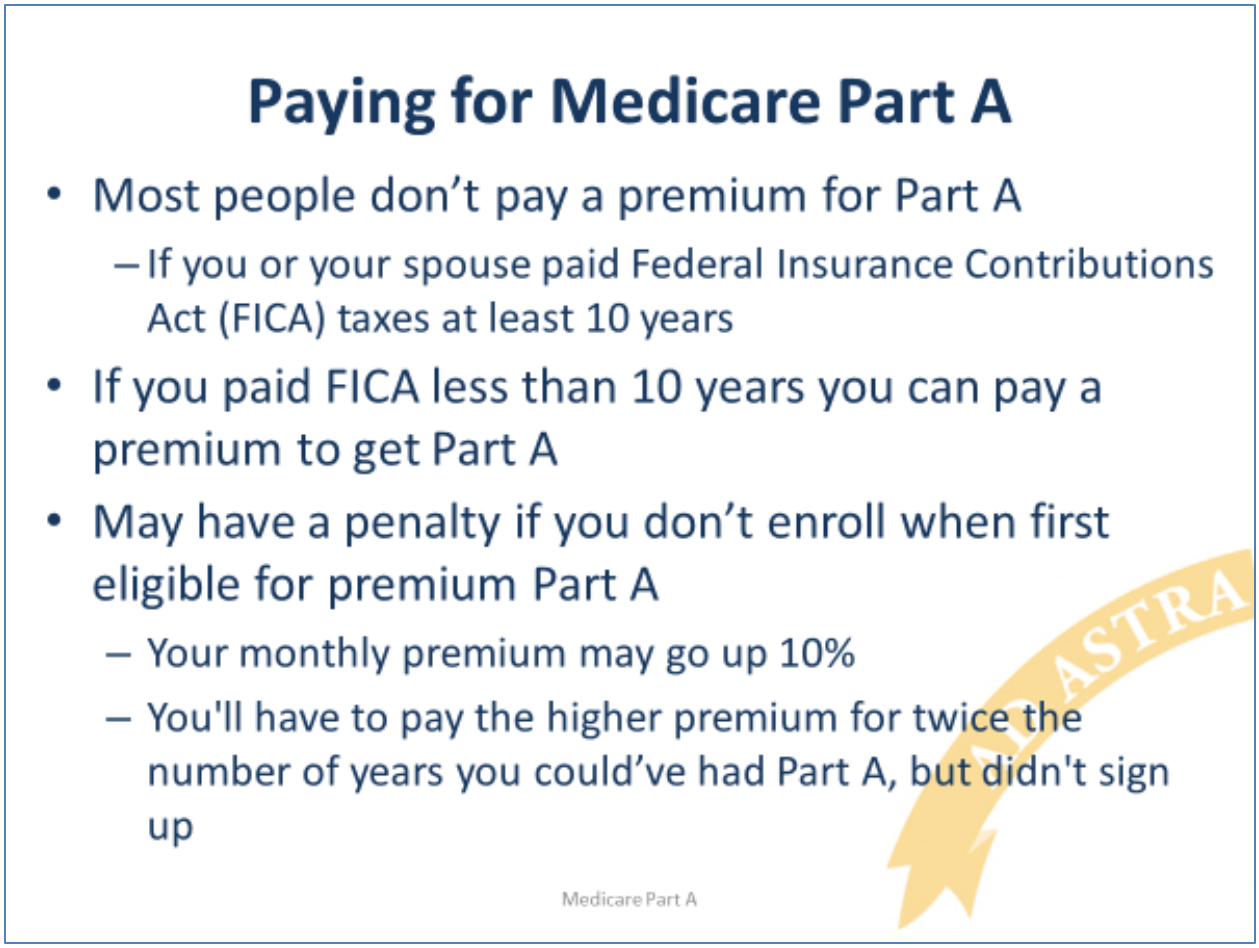


Here is more detail about what is covered under Part A:

- Blood—In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs)—Medicare will only cover the inpatient non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker.
- Home health care.
- Hospice care.

What's not covered?

Private-duty nursing, private room (unless medically necessary), television and phone in your room (if there's a separate charge for these items), and personal care items, like razors or slipper socks aren't covered by Medicare.



You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A. Federal Insurance Contributions Act (FICA) tax is a United States federal payroll (or employment) tax imposed on both employees and employers to fund Social Security and Medicare. About 99% of people with Medicare don't pay a Part A premium since they've at least 40 quarters of Medicare-covered employment. Enrollees 65 and over and certain persons with disabilities who have fewer than 40 quarters of coverage pay a monthly premium to receive coverage under Part A.

If you aren't eligible for premium-free Part A, you may be able to buy Part A if you're

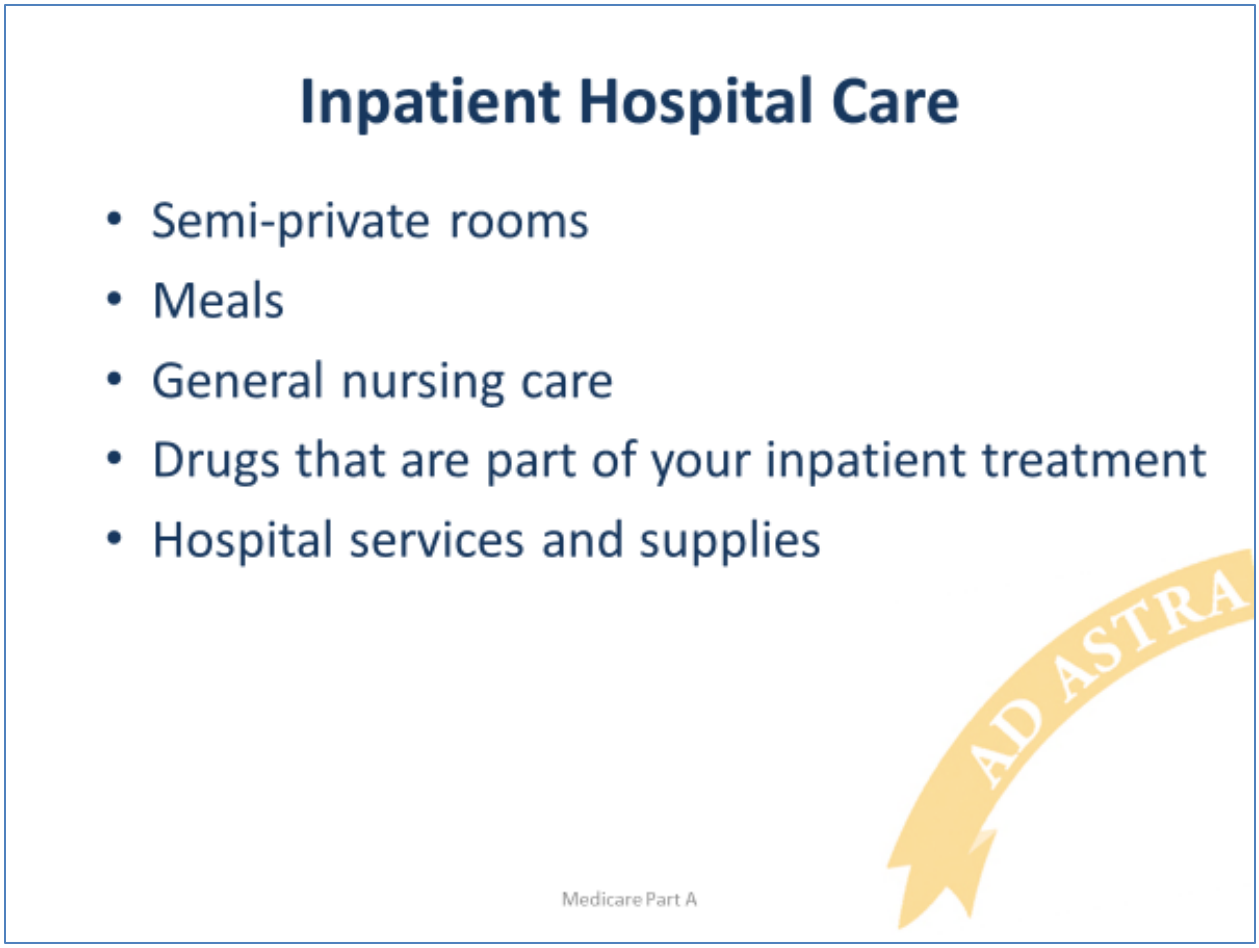
- 65 or older, and you have (or are enrolling in) Part B, and meet the citizenship and residency requirements.
- Under 65, have a disability, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and have a disability, you may continue to get premium-free Part A for up to 8 1/2 years after you return to work.)

In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

Social Security determines if you have to pay a monthly premium for Part A. In 2019, the Part A premium for a person who has worked less than 30 quarters of Medicare covered employment is $437 per month. Those who have between 30 and 39 quarters of coverage may buy Part A at a reduced monthly premium rate, which is $240 for 2019.

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10% for every 12 months you didn't have the coverage. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

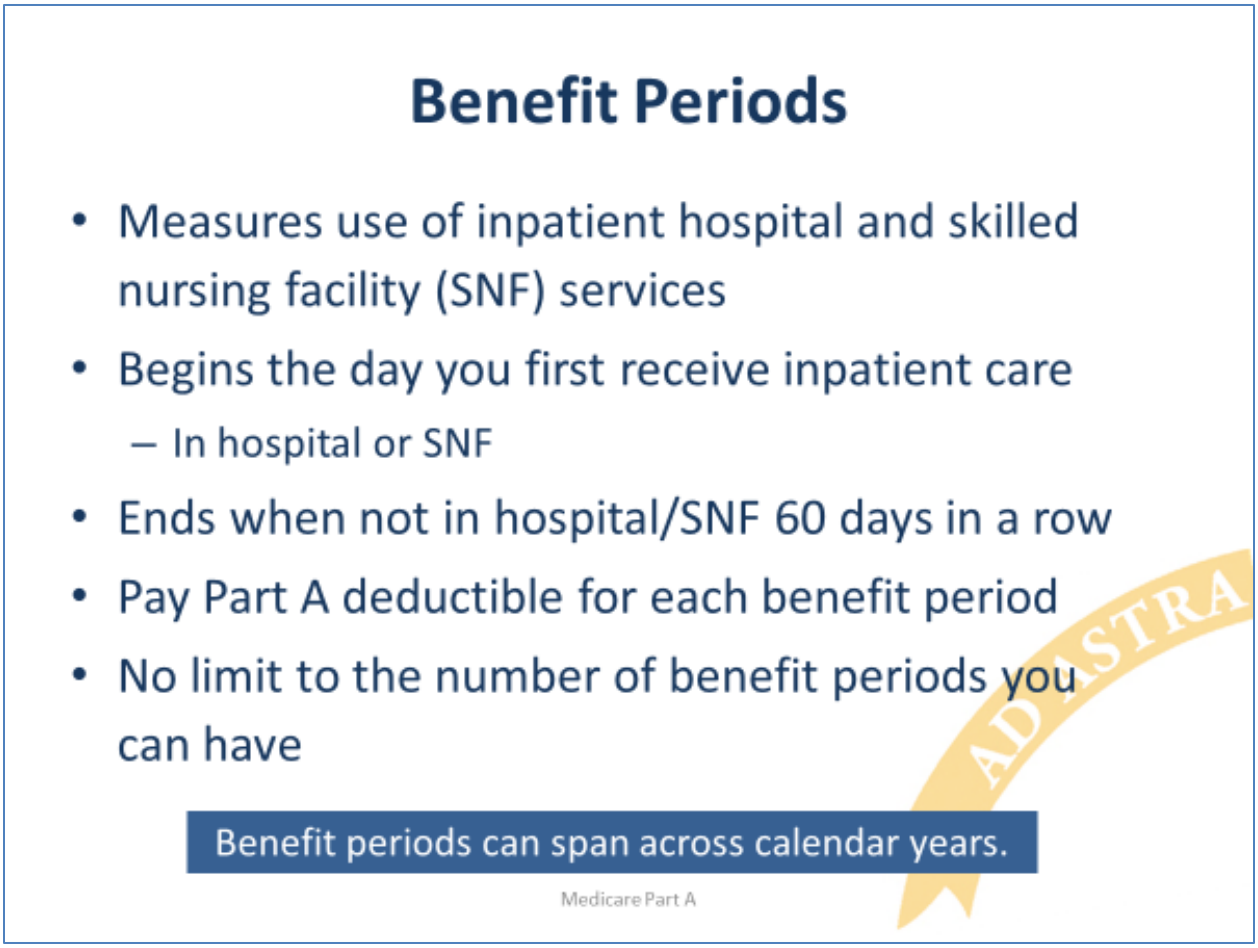
If you have limited income and resources, your state may help you pay for Part A and/or Part B. Call Social Security at 1-800-772–1213 for more information about the Part A premium. TTY: 1-800-325-0778.



Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital.

Medicare covers certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient, non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker. Medicare doesn't cover the religious portion of RNCHI care. Medicare Part A (Hospital Insurance) covers inpatient, non-religious, nonmedical care when certain conditions are met.

NOTE: Staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You're still an outpatient if you've not been formally admitted as an inpatient, even if you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. You or a family member should always ask if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility. For more information, read "Are You a Hospital Inpatient or Outpatient?" at Medicare.gov/Pubs/pdf/11435.pdf.

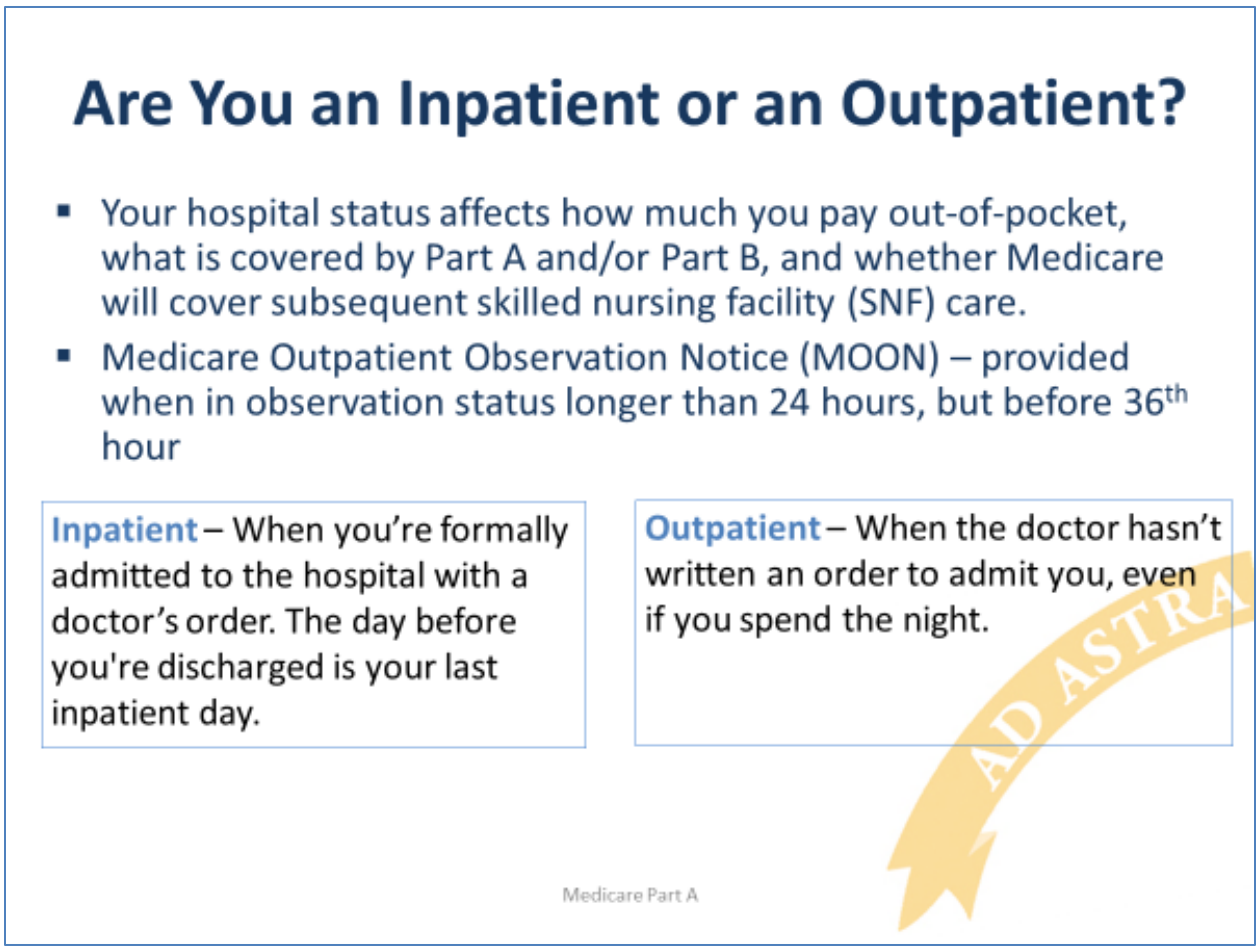


A benefit period refers to the way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care or SNF care for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the Part A inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. Benefit periods can span across calendar years.

Examples:

- You spend 5 days in the hospital. You then enter a SNF for 20 days of rehabilitation. You then return home. Your benefit period will end when you've been out of the SNF for 60 days, or 85 days after you first entered the hospital. If you don't return to the hospital as an inpatient in that time frame, you'll pay another deductible for the next benefit period.
- You've returned home after being an inpatient in the hospital, or in a combination of a hospital and a SNF. After 2 weeks at home you must return to the hospital. You haven't been out of inpatient care for 60 days, so you're still in your first benefit period. You don't have to pay another hospital deductible.

NOTE: To qualify for post-hospital extended care services (i.e. SNF), you must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.



Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects how much you pay for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility (SNF) following your hospital stay. You're an inpatient starting when you're formally admitted to a hospital with a doctor's order. The day before you're discharged is your last inpatient day.

You're an outpatient if you're getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor hasn't written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

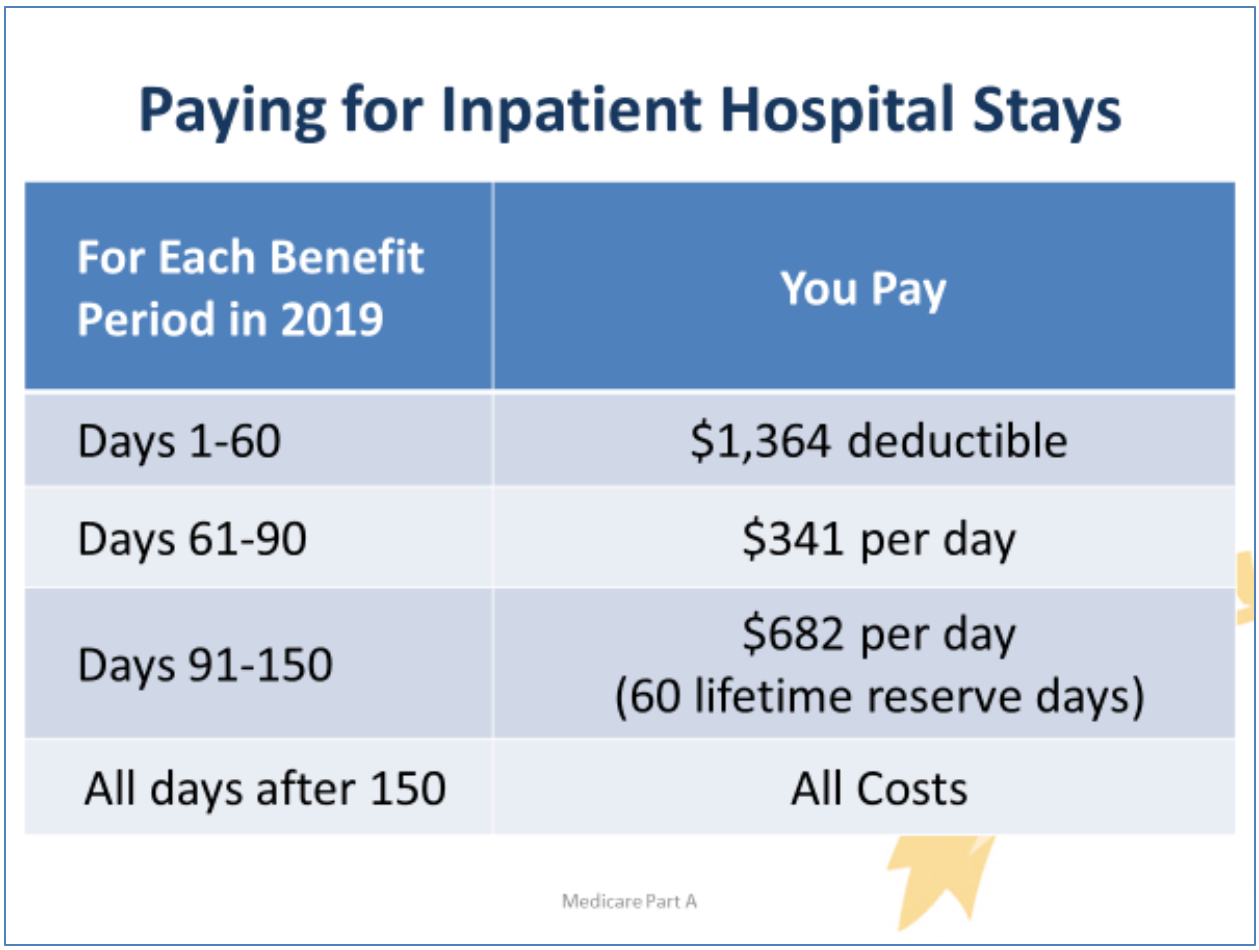
An inpatient admission is generally appropriate when you're expected to need 2 or more midnights of medically necessary hospital care, but your doctor must order such admission and the hospital must formally admit you for you to become an inpatient. If you have a Medicare Advantage Plan (like an HMO or PPO), your costs and coverage may be different. Check with your plan.

The copayment for a single outpatient hospital service can't be more than the inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

The Medicare Outpatient Observation Notice (MOON) (Form CMS 10611-MOON) is a standardized notice to inform people with Medicare (including health plan enrollees) that they are outpatients receiving observation services and aren't inpatients of a hospital or critical access hospital (CAH).

The MOON is to be provided if observation is longer than 24 hours, but before the 36th hour of observation.

For more information, visit CMS.gov/medicare/medicare-general-information/bni/.



For each benefit period in 2019 you pay

- $1,364 deductible and no copayment for days 1–60 each benefit period.
- $341 for days 61–90 each benefit period.
- $682 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime).
    - In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.
- All costs for each day after the lifetime reserve days.

NOTE: Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Deductible - The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Coinsurance - An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

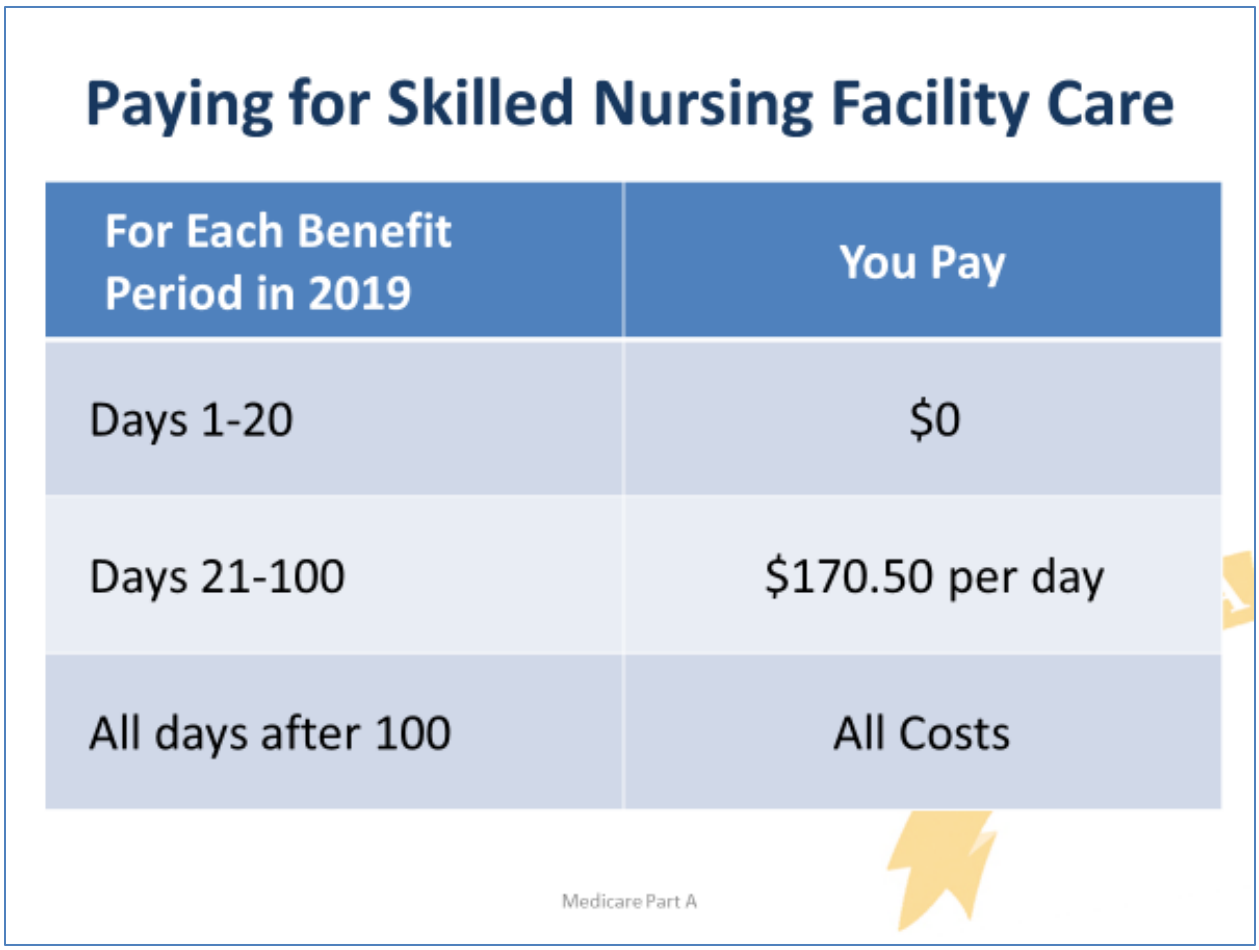
Part A will pay for skilled nursing facility (SNF) care if you meet the following conditions:

- Your doctor must certify that your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a SNF.
- This doesn't include custodial or long-term care. Medicare doesn't cover custodial care if it's the only kind of care you need. Custodial care is care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of a colostomy or bladder catheters. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.
- You were an inpatient in a hospital for 3 consecutive days or longer before you were admitted to a participating SNF. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in 1 or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.
- You were admitted to the SNF within 30 days after leaving the hospital.
- Your care in the SNF is for a condition that was treated in the hospital or arose while receiving care in the SNF for a hospital-treated condition.
- The facility must be a Medicare-participating SNF.

For more information, read "Medicare Coverage of Skilled Nursing Facility Care" at Medicare.gov/Pubs/pdf/10153.pdf.

If you qualify, Medicare will cover the following skilled nursing facility (SNF) services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications and medical supplies/equipment used in the facility
- Ambulance transportation to the nearest supplier of needed services that aren't available at the SNF when other transportation endangers health
- Dietary counseling



Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. In 2019, under Original Medicare, days 21–100 of SNF care are covered for each benefit period except for coinsurance of up to $170.50 per day. After 100 days, Medicare Part A no longer covers SNF care.

You can qualify for SNF care again every time you have a new benefit period and meet the other criteria.

Covered home health services include the following:

- ✓ Intermittent skilled nursing care
- ✓ Physical therapy
- ✓ Speech-language pathology services
- ✓ Continued occupational services, and more
- ✓ May also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment, or injectable osteoporosis drugs

Usually, a home health care agency coordinates the services your doctor orders for you.

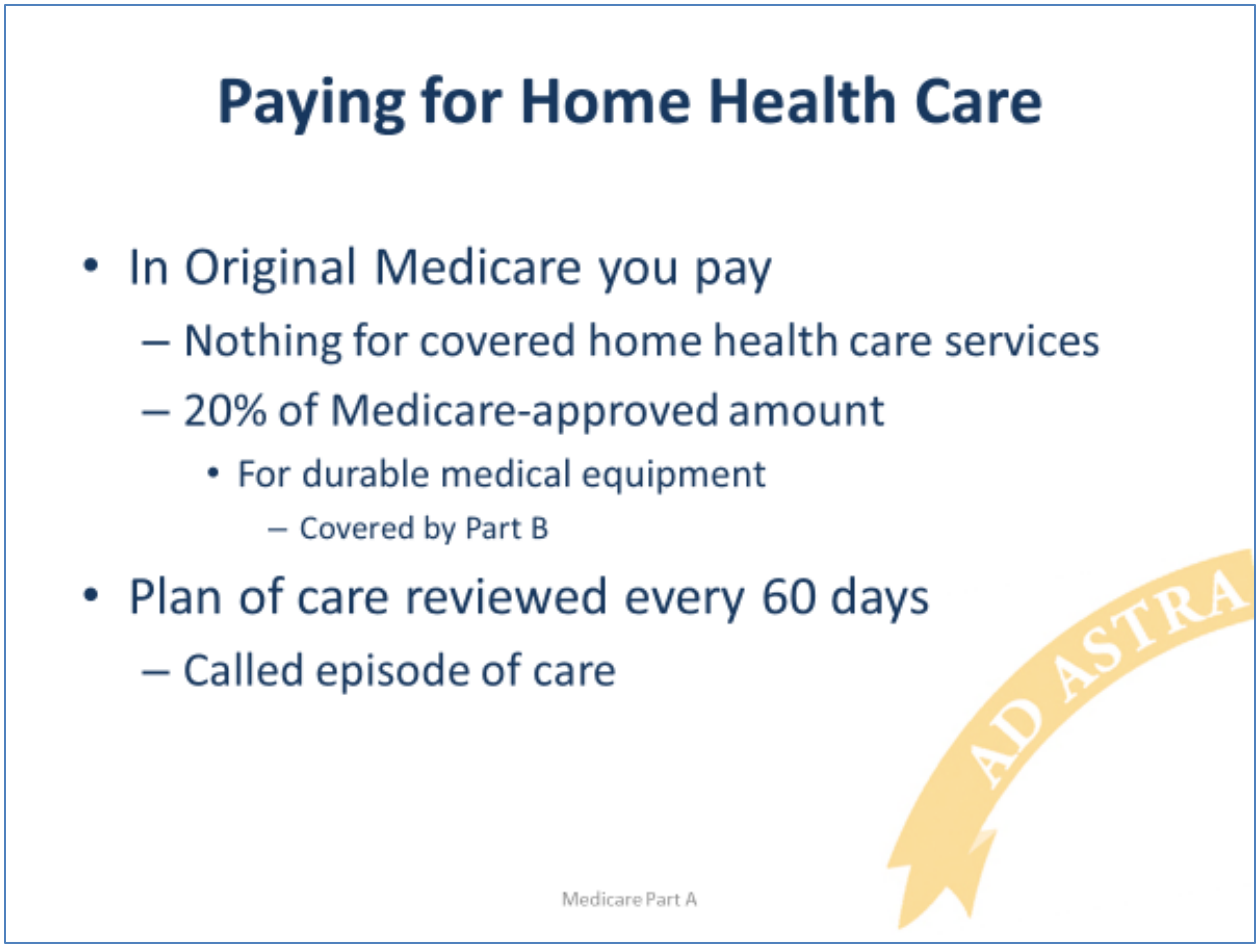
☒ Medicare doesn't pay for the following:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services
- Personal care

To be eligible for home health care services, you must meet all of these conditions:

1. You must be homebound. An individual shall be considered "confined to the home" (homebound) if the following 2 criteria are met: 1) The patient must either, because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence, OR 2) have a condition such that leaving his or her home is medically contraindicated. If the patient meets only 1 of the 2 previous conditions, then the patient must ALSO meet these 2 additional requirements: 1) There must exist a normal inability to leave home, AND 2) Leaving home must require a considerable and taxing effort.
2. You must need skilled care on an intermittent basis, or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy.
3. Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
4. Prior to certifying your eligibility for the Medicare home health benefit, the doctor must document that the doctor or other health care provider has had a face-to-face encounter with you. The encounter must be done up to 90 days prior, or within 30 days after the start of care. The law allows the face-to-face encounter to occur via telehealth in rural areas, in an approved originating site. This means medical or other health services given to a patient using a communications system (like a computer, phone, or television), by a health care provider in a location different from the patient's.
5. The home health agency caring for you must be approved by Medicare.

NOTE: Part B also may pay for home health care under certain conditions. For instance, Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A–covered home health care visits exceed 100. For more information, read "Medicare and Home Health Care," at Medicare.gov/Pubs/pdf/10969.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

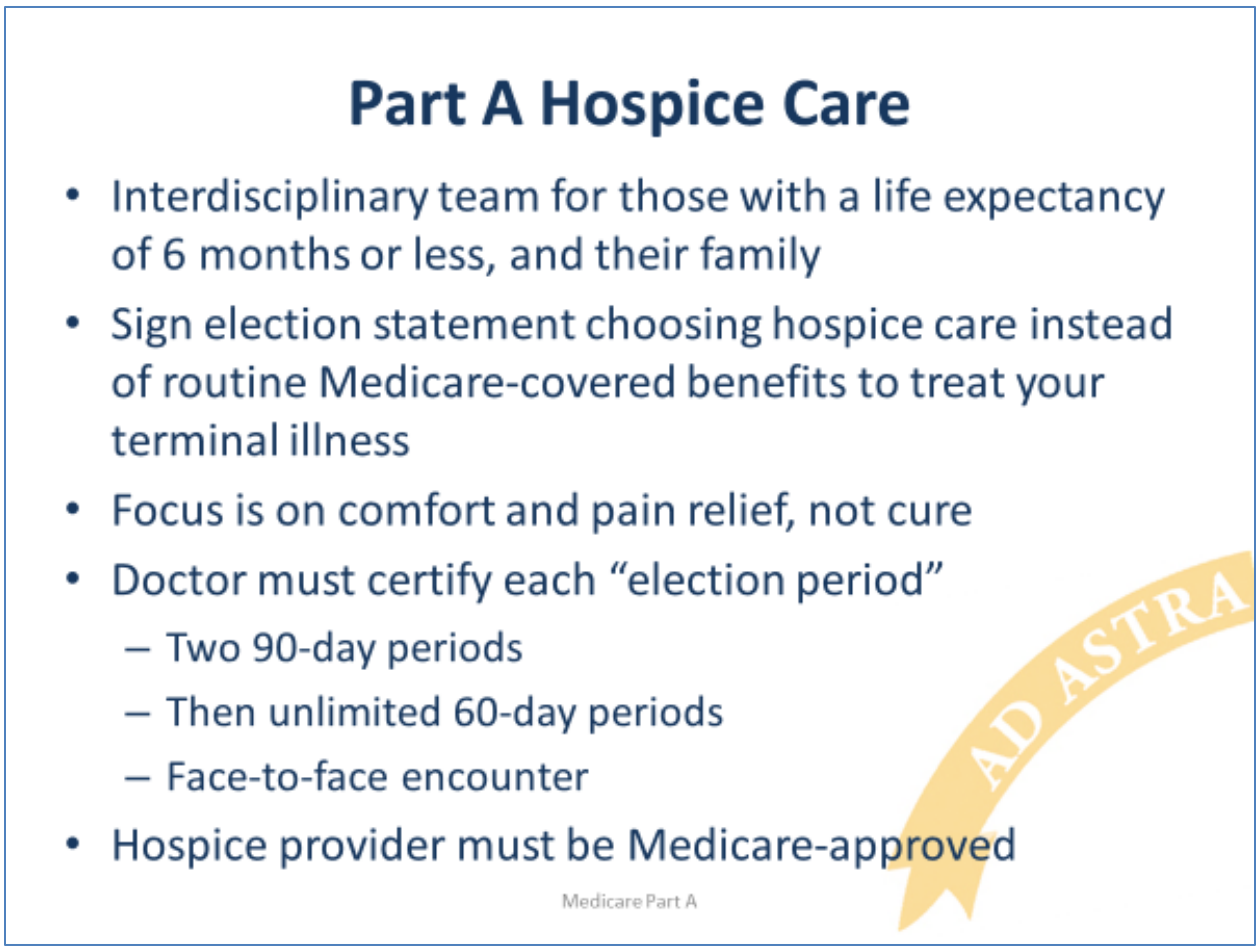


In Original Medicare, for Part A covered home health care, you pay nothing for covered home health care services provided by a Medicare-approved home health agency.

Durable medical equipment, when ordered by a doctor, is paid separately by Medicare. This equipment must meet certain criteria to be covered. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, such as a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

To find a home health agency in your area, visit Medicare.gov and use the Home Health Compare tool, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

NOTE: Part A covers post-institutional home health services furnished during a home health "spell of illness" for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health "spell of illness." The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.



Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

You must sign an election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness. However, medical services not related to your hospice condition would still be covered by Medicare.

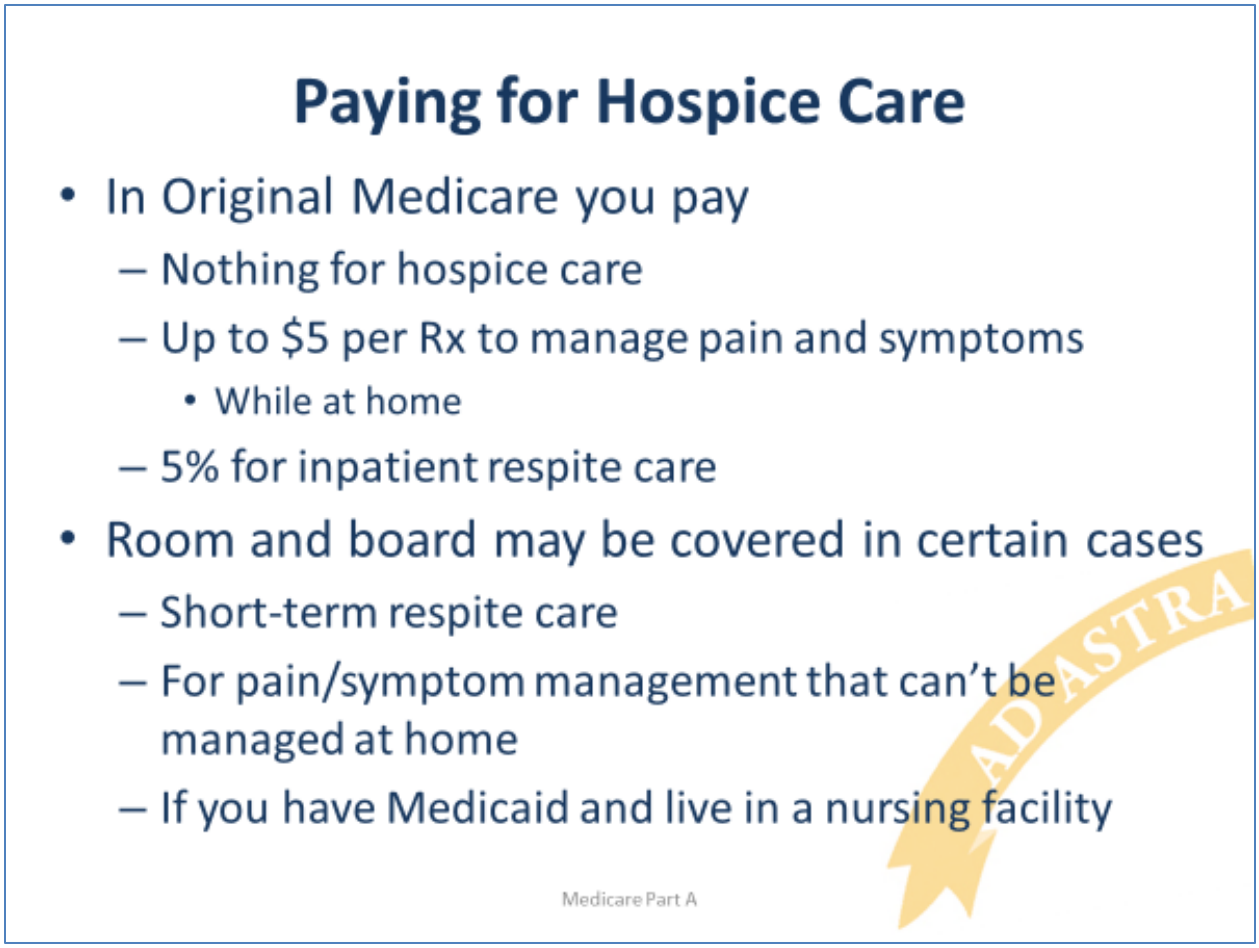
You can get hospice care as long as your doctor certifies that you're terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "election periods"—two, 90-day periods, followed by unlimited 60-day periods. At the start of each benefit period, your doctor must certify that you're terminally ill for you to continue getting hospice care.

Medicare also requires face-to-face visits. The doctor is required to meet with you within 30 days of hospice recertification, starting before the third election period and each subsequent recertification.

The hospice provider must be Medicare-approved.
For more information, read "Medicare Hospice Benefits" at Medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF.

In addition to the regular Medicare-covered services, such as doctor and nursing care, physical and occupational therapy, and speech language therapy, the hospice benefit also covers:

- Medical equipment (such as wheelchairs or walkers).
- Medical supplies (such as bandages and catheters).
- Drugs for symptom control and pain relief.
- Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management.
- Inpatient respite care, which is care given to you by another caregiver, so your usual caregiver can rest. You'll be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there's no limit to the number of times you can get respite care. Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care when needed.
- Hospice aide and homemaker services.
- Social worker services.
- Other covered services as well as services Medicare usually doesn't cover, like spiritual and grief counseling.
- Dietary and other counseling.

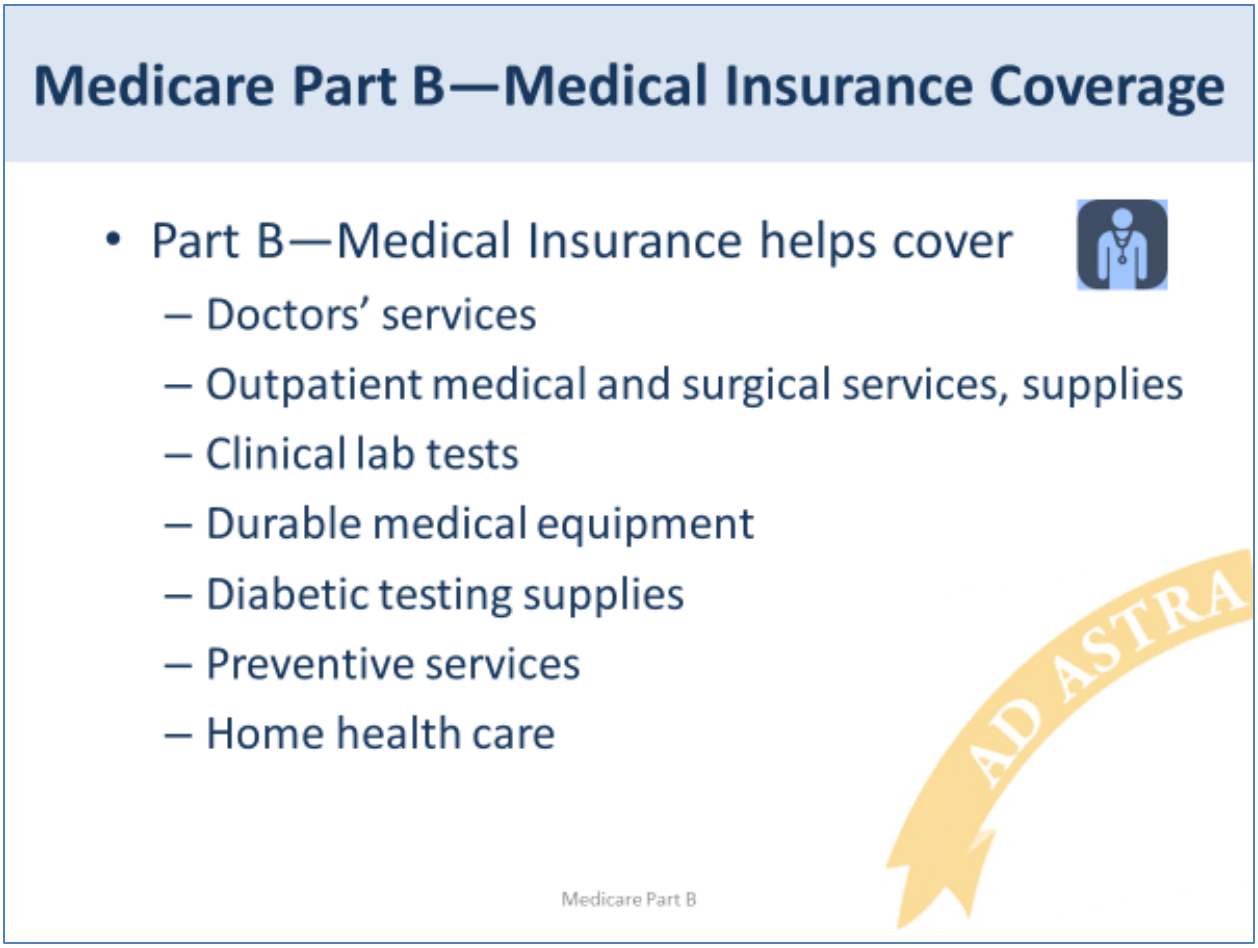


For hospice care in Original Medicare, you pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while receiving routine or continuous care at home, and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you'll pay $7.50 per day. The amount you pay for respite care can change each year.

Room and board are only payable by Medicare in certain cases. Room and board are covered during short-term inpatient stays for pain and symptom management, and for respite care. Room and board aren't covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, if you have Medicaid as well as Medicare, and reside in a nursing facility, room and board are covered by Medicaid.

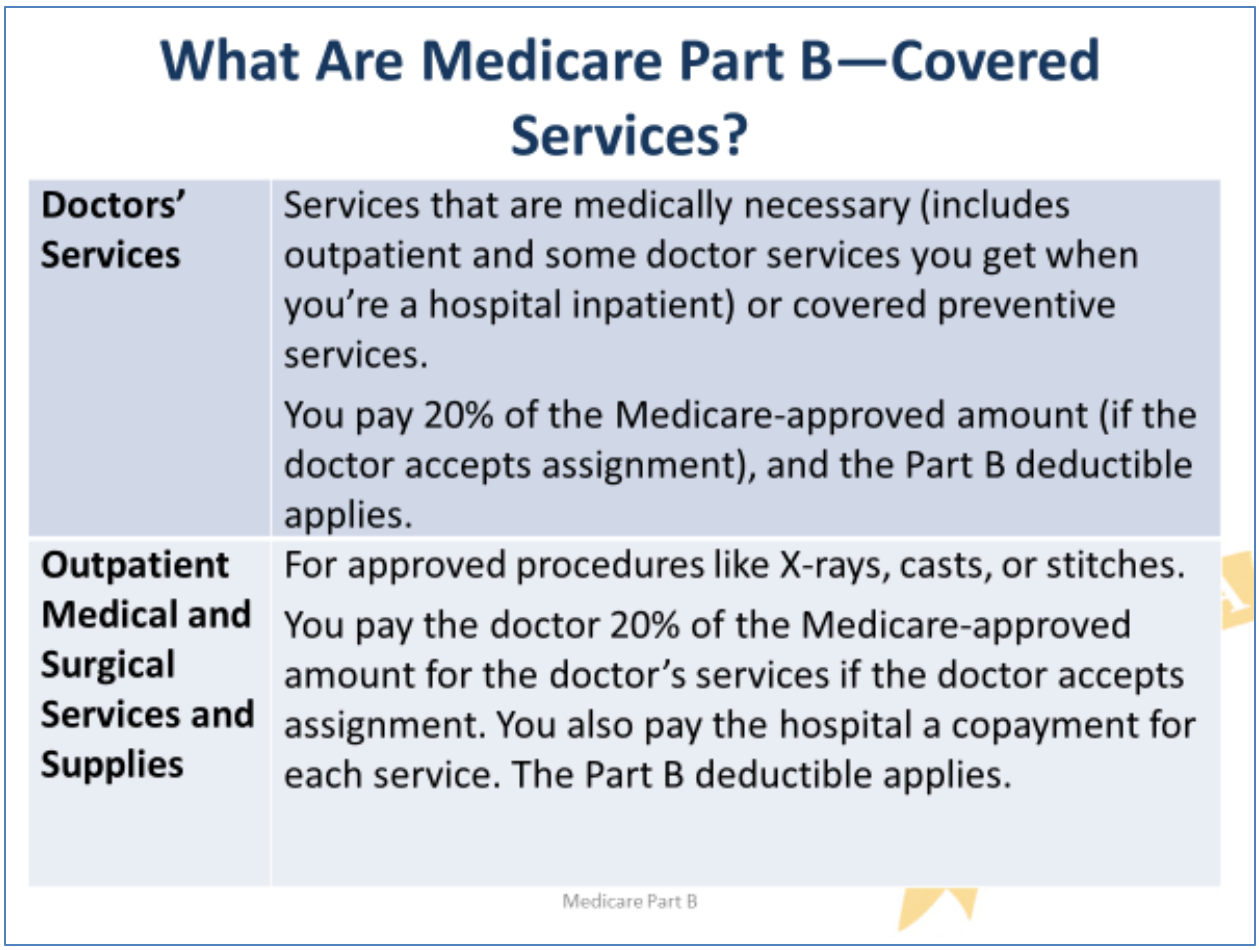
To find a hospice program, call 1-800-MEDICARE (1-800-633-4227), or your state hospice organization. TTY: 1-877-486-2048.

For more information, visit the "Medicare Benefit Policy Manual", Chapter 9, Coverage of Hospice Services under Hospital Insurance at CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf.



Medicare Part B (Medical Insurance) helps cover medically necessary outpatient services and supplies.

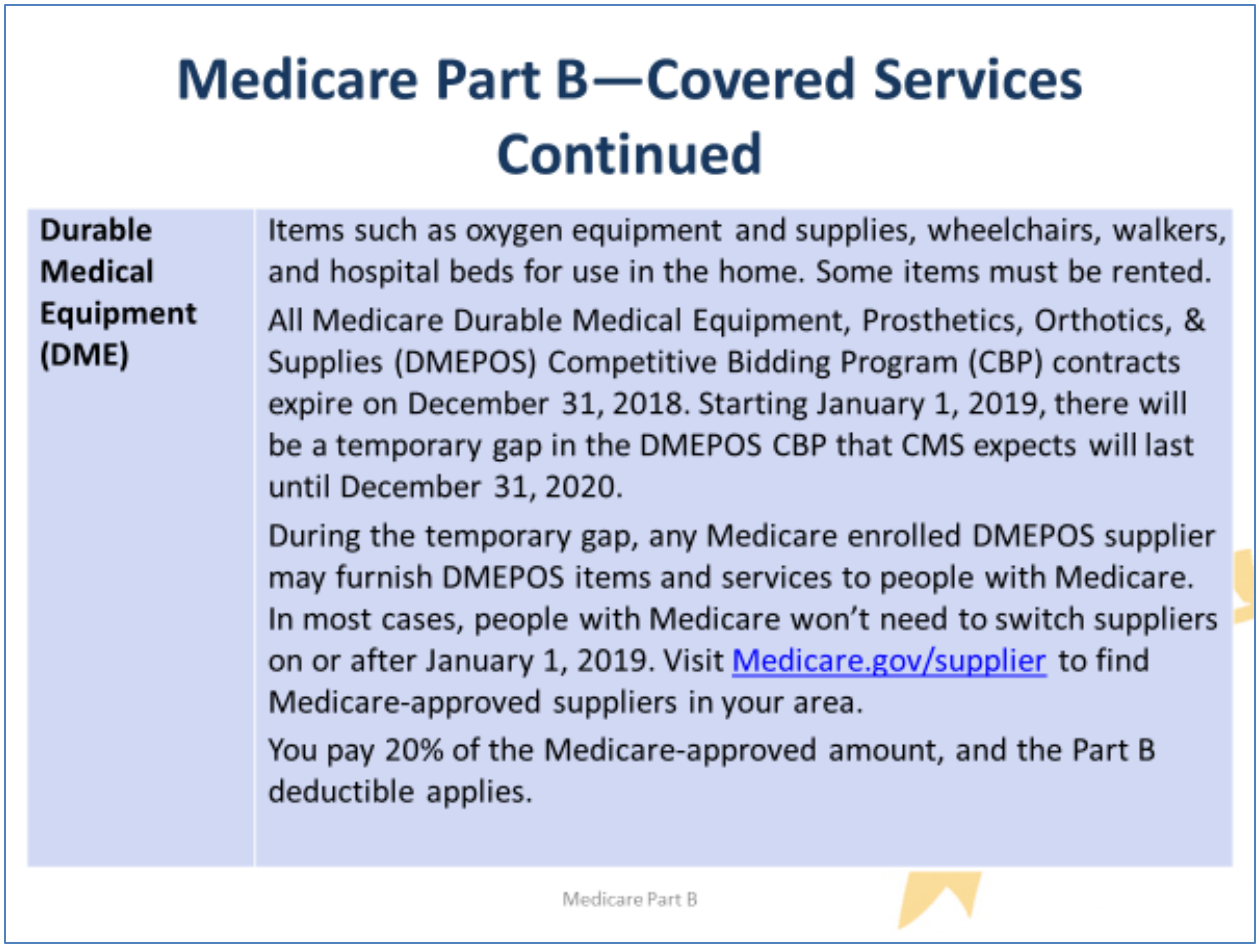
- Doctors' services—Services that are medically necessary.
- Outpatient medical and surgical services and supplies—For approved procedures like X-rays or stitches.
- Clinical laboratory services—Blood tests, urinalysis, and some screening tests.
- Durable medical equipment like walkers and wheelchairs—You may need to use certain suppliers under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program. Visit Medicare.gov/supplierdirectory/.
- Diabetic testing supplies—You may need to use specific suppliers for some types of diabetic testing supplies.
- Preventive services—Exams, tests, screening and shots to prevent, find, or manage a medical problem.
- Home health services – You can use your home health benefits under Part A and/or Part B. Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A-covered home health care visits exceed 100. For more information, read "Medicare and Home Health Care," at Medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.



Medicare Part B covers a variety of medically necessary outpatient services and supplies. Certain requirements must be met.

Doctors' Services—Medicare covers medically necessary doctor services (including outpatient and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Outpatient Medical and Surgical Services and Supplies—Medicare covers approved procedures like X-rays, casts, or stitches. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. The Part B deductible applies.

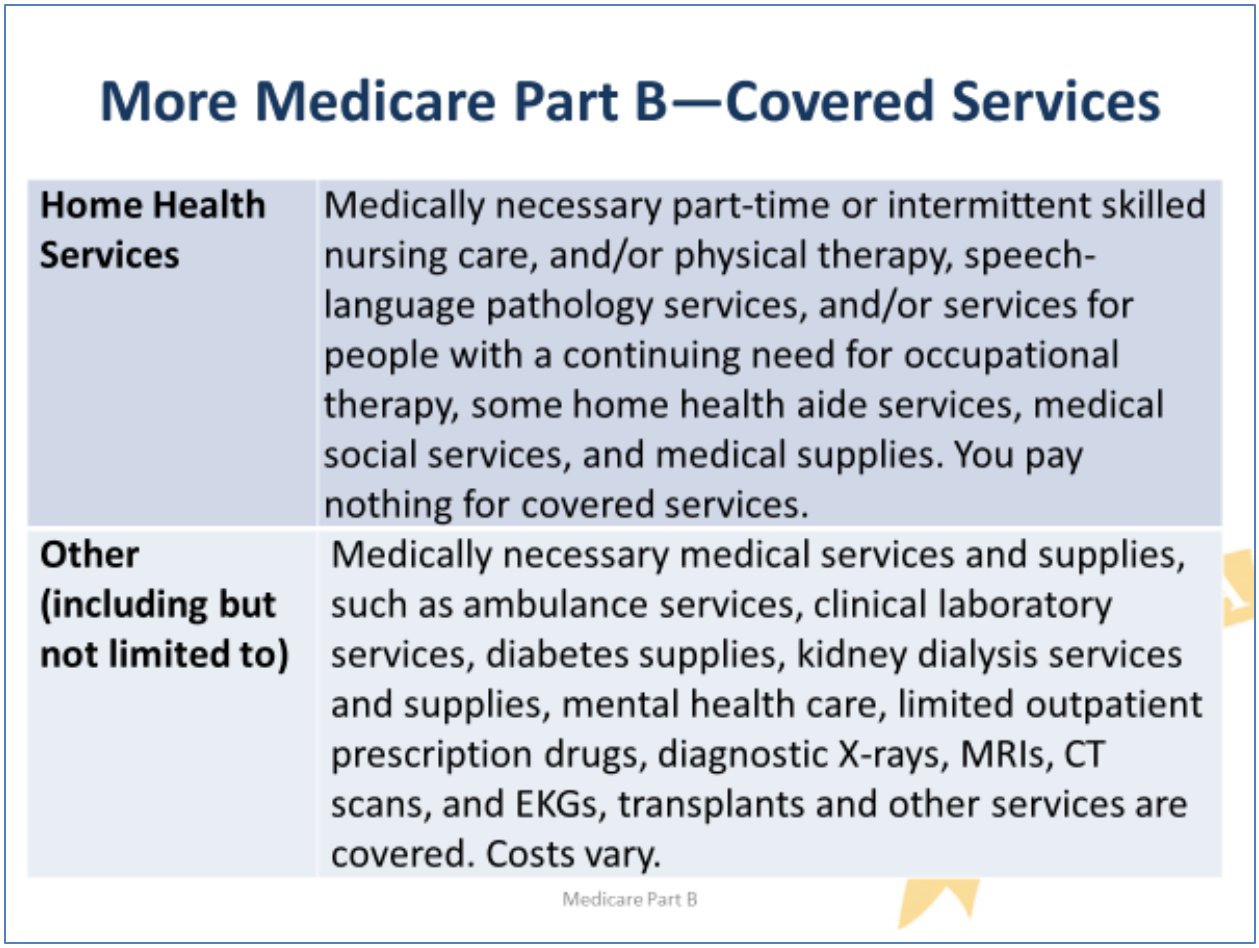


Durable Medical Equipment (DME)—Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.

All Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program contracts expired on December 31, 2018. As of January 1, 2019, there is a temporary gap in the entire DMEPOS Competitive Bidding Program that CMS expects will last until December 31, 2020. For additional information, please see the Temporary Gap Period fact sheet.

If you need DME or supplies, visit Medicare.gov/supplier to find Medicare-approved suppliers. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

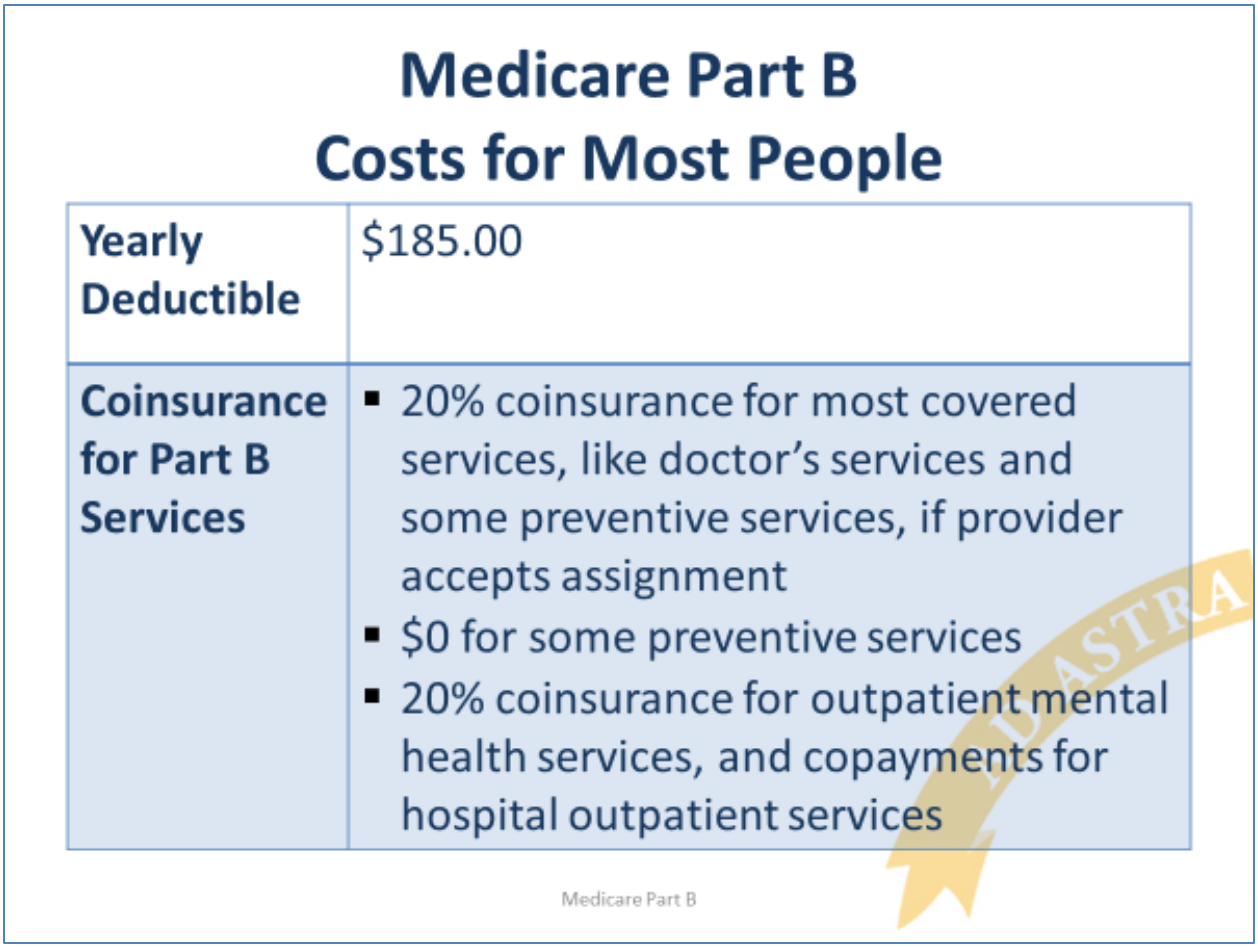
For more information on the competitive bidding program, you can visit: CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/.



Home Health Services—Medicare covers medically-necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, as defined previously. You pay nothing for covered home health services.

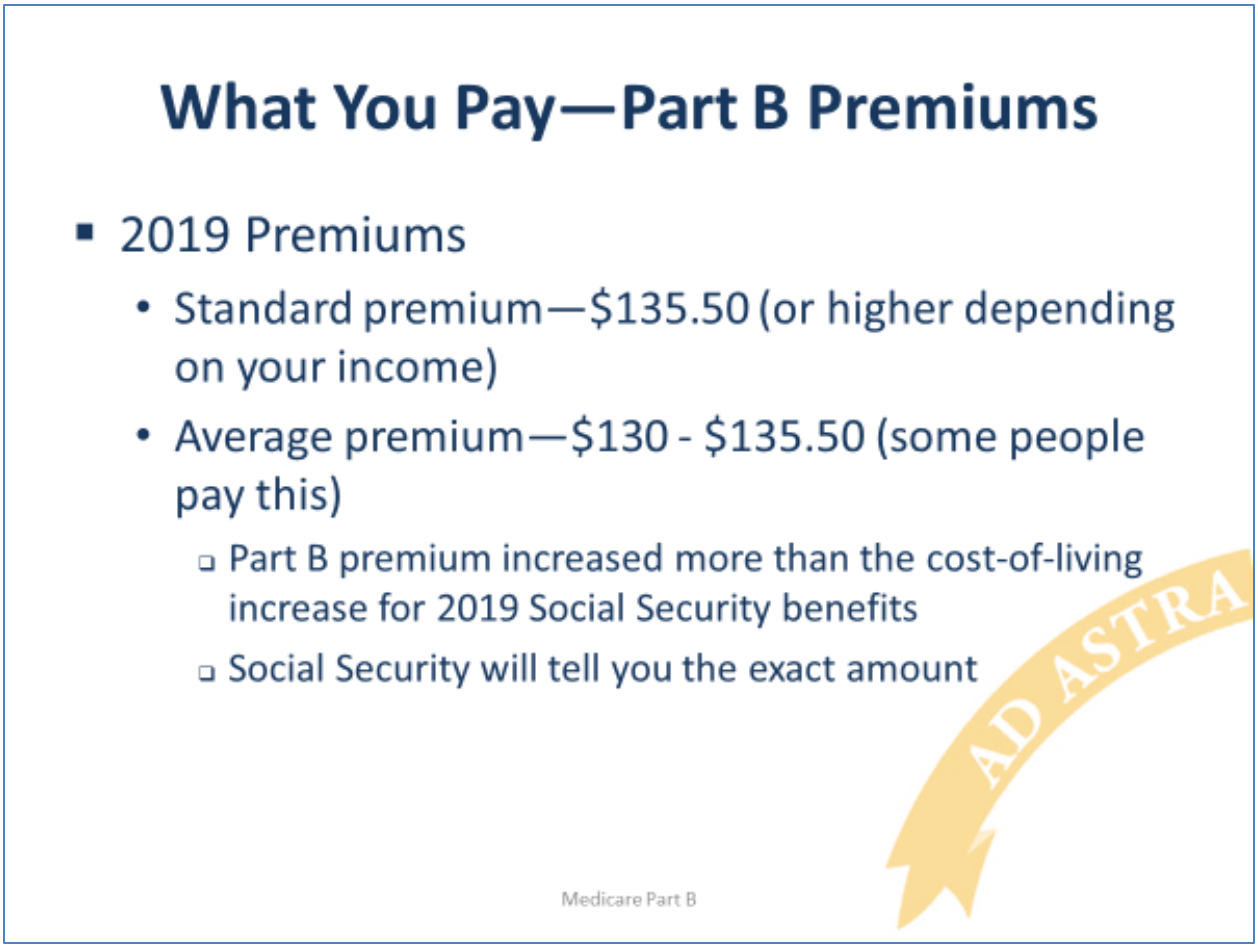
NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B. For more information on Part B coverage, visit Medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html.

Other (including, but not limited to)—Ambulance services, medically necessary clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited prescription drugs, diagnostic X-rays, MRIs, CT scans, EKGs, transplants, and other services are covered. Costs vary.



In addition to premiums, there are other costs you pay in Original Medicare. This is what you pay in 2019 for Part B covered medically necessary services:

- The annual Part B deductible is $185 in 2019. If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. This means that you must pay the first $185 of your Medicare-approved medical bills in 2019 before Part B starts to pay for your care.
- Coinsurance for Part B services. In general, it's 20% for most covered services for providers accepting assignment.
- Some preventive services have no coinsurance, and the Part B deductible doesn't apply as long as the provider accepts assignment (see pages 46-47).
- You pay 20% for outpatient mental health services (visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions, or outpatient treatment of your condition [like counseling or psychotherapy] for providers accepting assignment).
- If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.



You pay a premium for Part B each month. The standard Part B premium amount in 2019 is $135.50 (or higher depending on your income). However, some people who get Social Security benefits will pay less than this amount. This is because the Part B premium increased more than the cost-of-living increase for 2019 Social Security benefits. If you pay your Part B premium through your monthly Social Security benefit, you'll pay less. Social Security will tell you the exact amount you will pay for Part B.

REMEMBER: This premium may be higher if you didn't choose Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but didn't take it. An exception would be if you can enroll in Part B during a Special Enrollment Period because you or your spouse (or family member if you're disabled) is still employed and you're covered by a group health plan through that employment.

Those who'll pay the standard premium ($135.50.00 or higher) in 2019 include people in one of these 5 groups:

- You enroll in Part B for the first time in 2019
- You don't get Social Security benefits
- You're directly billed for your Part B premiums
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $135.50).
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount. If so, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium (see next page).

Monthly Part B Standard Premium—Income-Related Monthly Adjustment Amount for 2019

Chart is based on your yearly income *in 2017* (for what you pay in 2019)

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	In 2019 You Pay
$85,000 or less	$170,000 or less	$85,000 or less	$135.50
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	Not applicable	$189.60
Above $107,000 Up to $133,500	Above $214,000 Up to $133,500	Not applicable	$270.90
Above $133,500 Up to $160,000	Above $267,000 Up to $320,000	Not applicable	$352.20
Above $160,000 and less than $500,000	Above $320,000 and less than $750,000	Above $85,000 and less than $415,000	$433.40
$500,000 and above	$750,000 and above	$415,000 and above	$460.50

NOTE: You may pay more if you have a Part B late enrollment penalty.

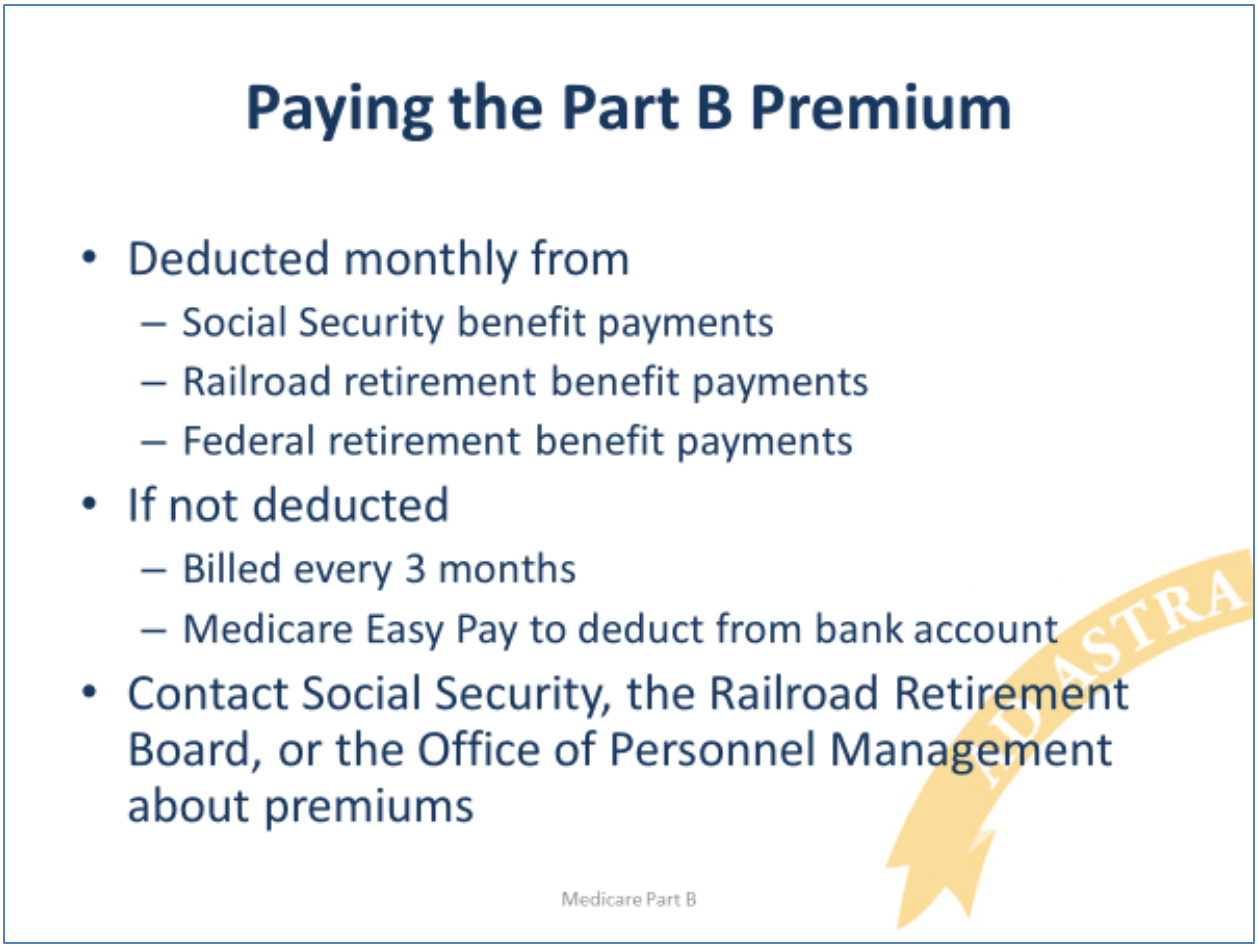
Medicare Part B

Since 2007, people with Medicare with higher incomes have paid higher Medicare Part B monthly premiums. These income-related monthly premium rates affect roughly 5% of people with Medicare. The total Medicare Part B premiums for people with high income for 2019 are shown in the following table:

For those whose income is

- $85,000 or less, and file an individual tax return, file a joint tax return with a yearly income of $170,000 or less, or file married with separate tax returns, the Part B premium is $135.50 per month.
- $85,000.01–$107,000, and file an individual tax return, file a joint tax return with a yearly income above $170,000 up to $214,000, the Part B premium is $189.60 per month.
- $107,000.01–$133,500, and file an individual tax return, file a joint tax return with a yearly income of above $214,000 up to $267,000, the Part B premium is $270.90 per month.
- $133,500.01–$160,000, and file an individual tax return, file a joint tax return with an income above $267,000 up to $320,000, the Part B premium is $352.20 per month.
- Above $160,000 and less than $500,000, and file an individual tax return, file a joint tax return with an income above $320,000 and less than 4750,000, or file married and file separate tax return with an income above $85,000 and less than $415,000, the Part B premium is $433.40 per month.
- $500,000 and above and file an individual tax return, file a joint tax return with a yearly income of above $750,000, or file married and file separate tax return with an income above $415,000, the Part B premium is $460.50 per month

If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213. TTY: 1-800-325-0778.

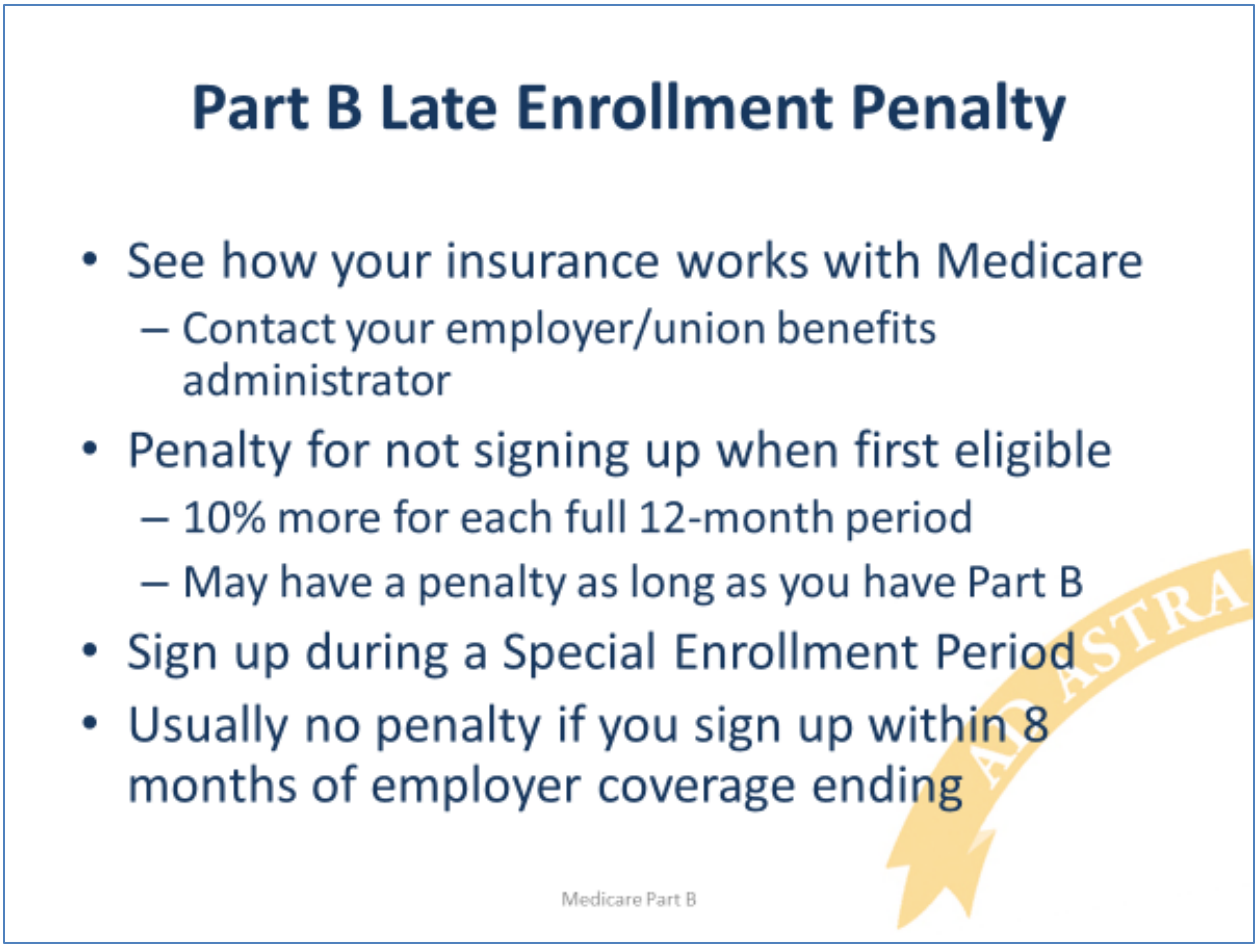


The Part B premium is deducted from monthly Social Security, Railroad Retirement, or federal retirement benefit payments.

If you don't get a retirement payment or your payment isn't enough to cover the premium, you'll get a bill from Medicare for your Part B premium. The bill can be paid by credit card, check, or money order.

For information about Medicare Part B premiums, call Social Security, the Railroad Retirement Board, or the Office of Personnel Management for retired federal employees.

If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.

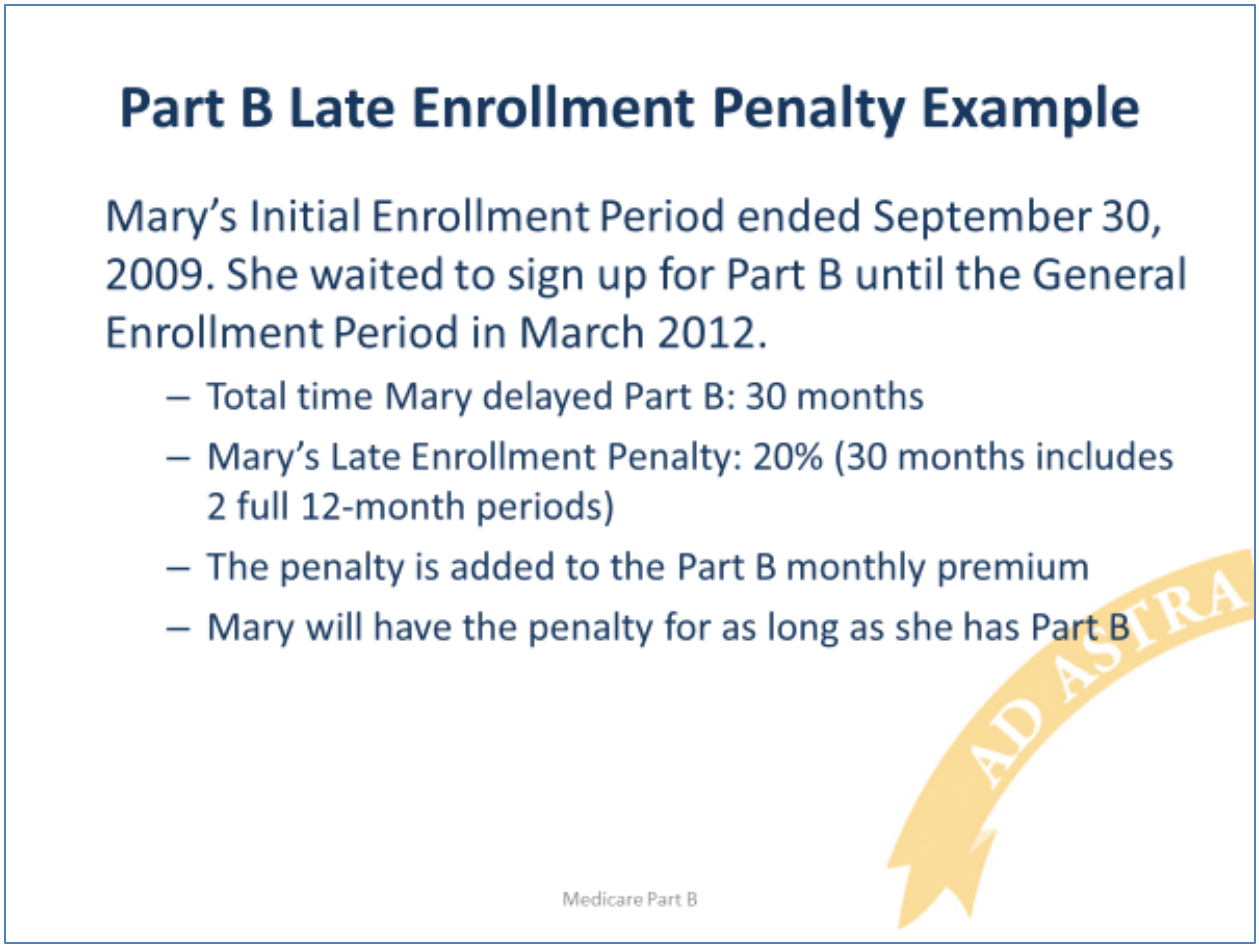


If you don't take Part B when you're first eligible, you may have to wait to sign up during the annual General Enrollment Period that runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.

If you don't take Part B when you're first eligible, you'll have to pay a premium penalty of 10% for each full 12-month period you could've had Part B but didn't sign up for it, except in special situations. In most cases, you'll have to pay this penalty for as long as you have Part B.

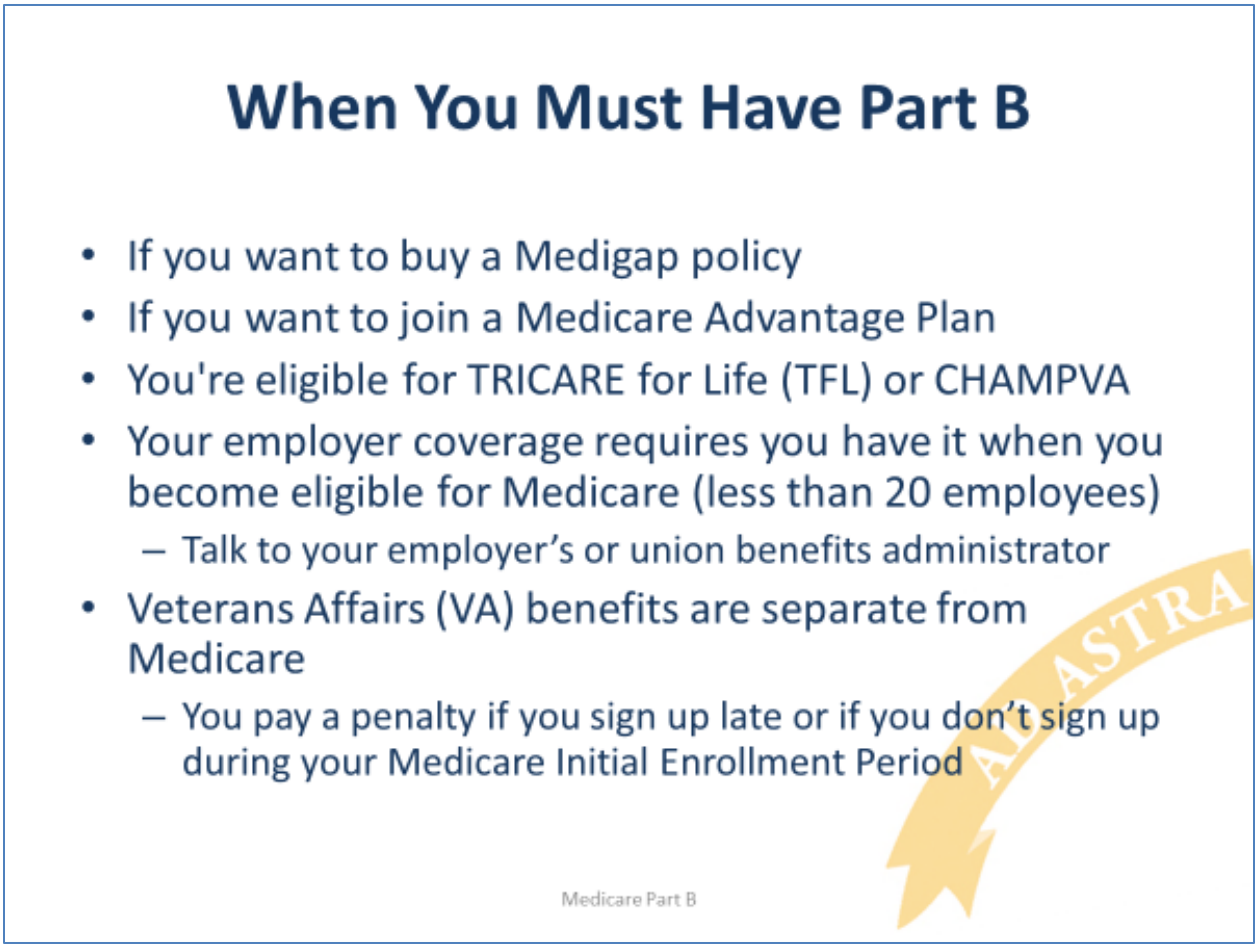
Having coverage through an employer (including federal or state employment, but not military service) or union while you or your spouse (or family member if you're disabled) is still working can affect your Part B enrollment rights. If you're covered through active employment (yours or your spouses), you have a Special Enrollment Period (SEP). This means you can join Part B anytime that you or your spouse (or family member if you're disabled) is working, and covered by a group health plan through the employer or union based on that work, or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first. Usually, you don't pay a late enrollment penalty if you sign up during a SEP. This SEP doesn't apply to people with End-Stage Renal Disease.

You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment.



This is an example of how you might calculate a late enrollment penalty for Part B. Mary's Initial Enrollment Period ended September 30, 2009. She waited to sign up for Part B until the General Enrollment Period in March 2012.

- Total time Mary delayed Part B: 30 months
- Mary's Late Enrollment Penalty: 20% (30 months includes 2 full 12-month periods)
- The penalty is added to the Part B monthly premium
- Mary will have the penalty for as long as she has Part B



You must have Part B if

- You want to buy a Medicare Supplement Insurance (Medigap) Policy
- You want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL)* or Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Your employer coverage requires you or your spouse/family member to have it when you become eligible for Medicare—less than 20 employees (talk to your employer's or union benefits administrator)

Veterans Affairs (VA) benefits are separate from Medicare. With VA benefits, you may choose to not enroll in Part B, but you pay a penalty if you don't sign up for Part B during your Initial Enrollment Period (visit VA.gov). If you have VA coverage, you won't be eligible to enroll in Part B using the Special Enrollment Period (SEP).

*TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to get TFL benefits. However, if you're an active-duty service member, or the spouse or dependent child of an active-duty service member, you don't have to enroll in Part B to keep your TRICARE coverage. When the active-duty service member retires, you must enroll in Part B to keep your TFL coverage. You can get Part B during a Special Enrollment Period if you have Medicare because you're 65 or older, or you're disabled. For more information, visit Tricare.mil/mybenefit.

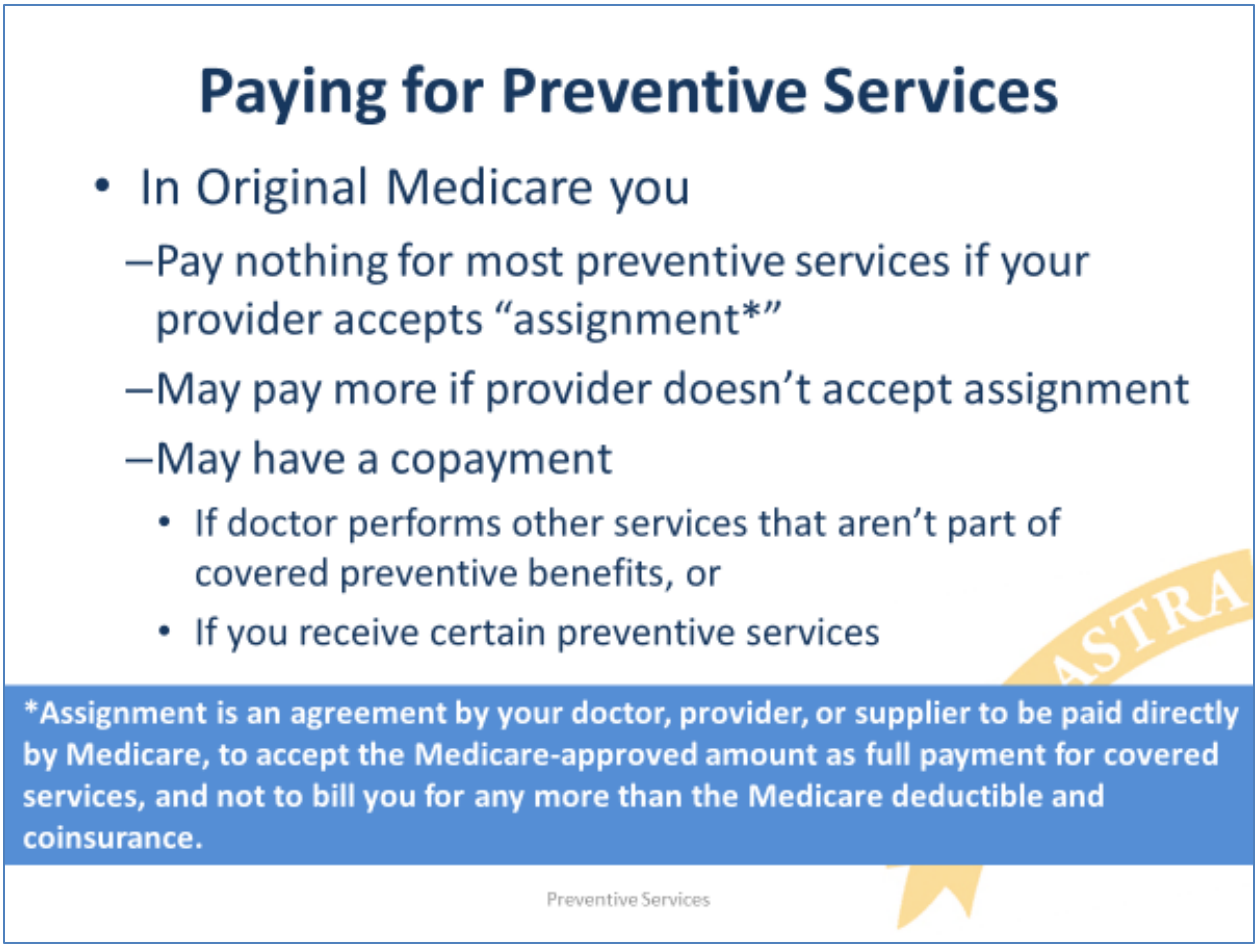
You must have Part A and Part B to keep your CHAMPVA coverage.

NOTE: See also Medicare.gov/Pubs/pdf/02179.pdf for more information on "Who Pays First."

Medicare Preventive Services

- Medicare preventive services
  - May find health problems early, when treatment works best
- Covered by Medicare Part B (Medical Insurance)
  - Whether you get your coverage from
    - Original Medicare
    - Medicare Advantage (MA) Plan
    - Other Medicare health plans
- Coverage for preventive services is based on age, gender, and medical history

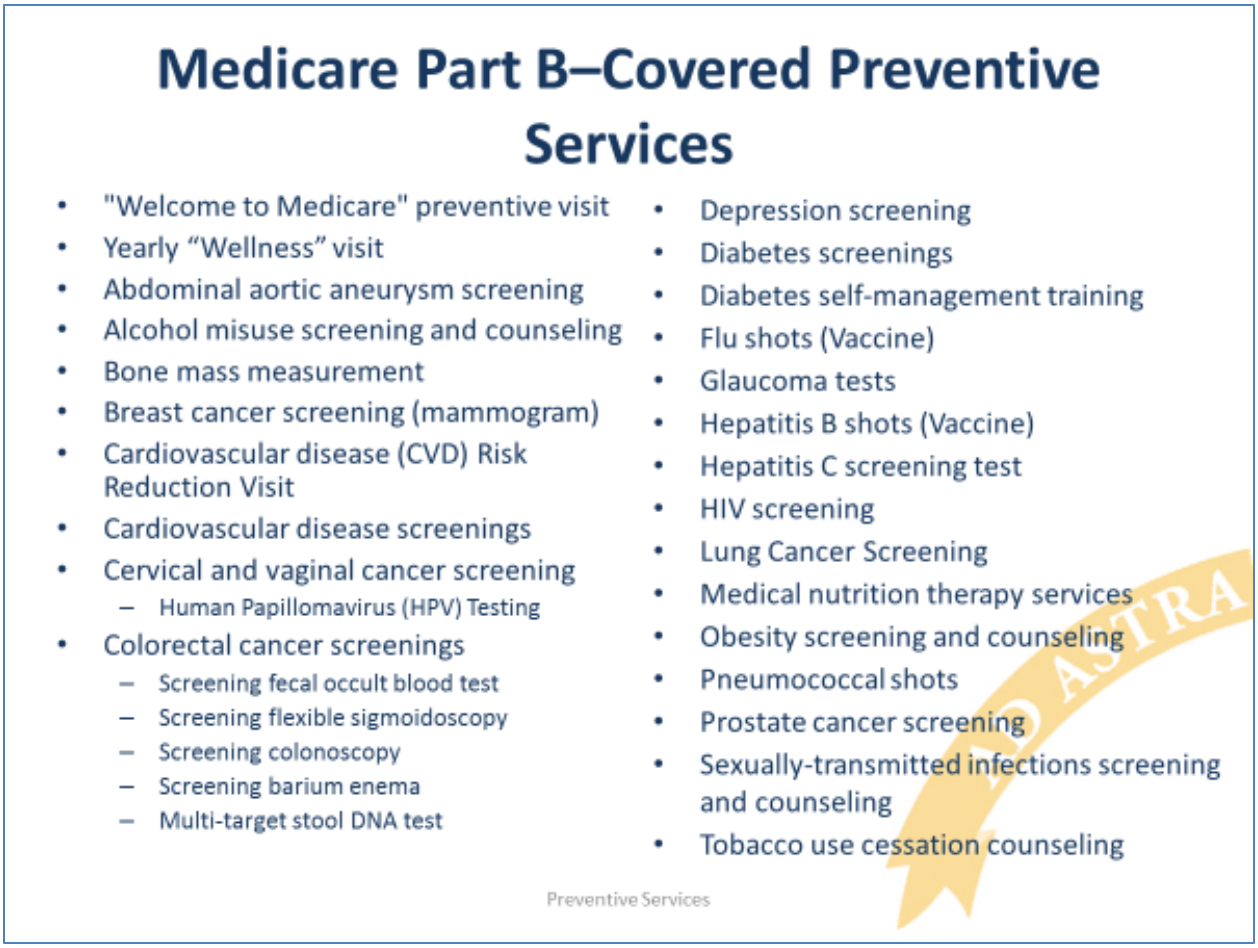
Preventive Services



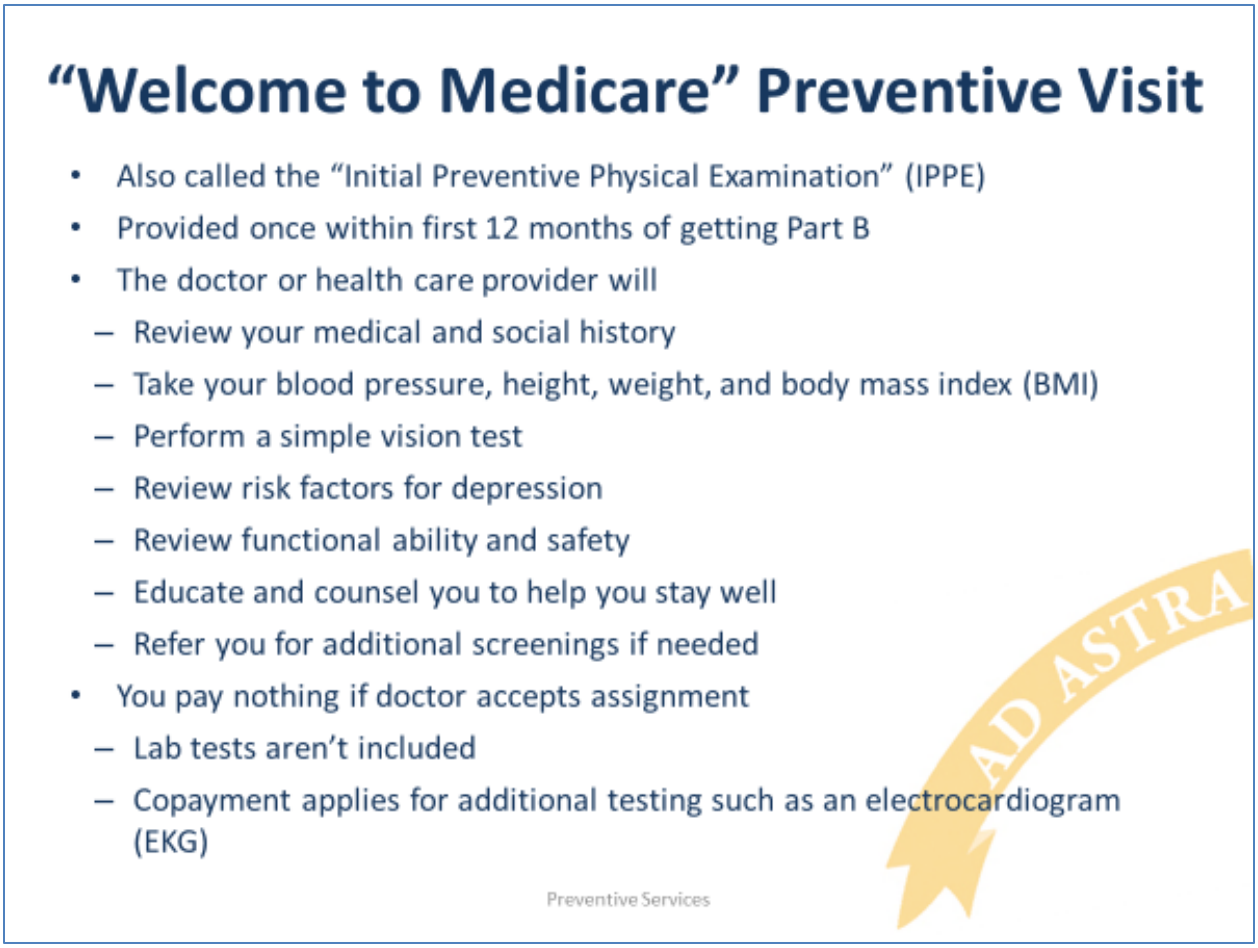
Under Original Medicare, you'll pay nothing for most preventive services if you get the services from a doctor or other provider who accepts the assignment.

The assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services, and not to bill you for any more than the Medicare deductible and coinsurance.

You'll pay nothing for certain preventive services. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under the preventive benefits, you may have to pay a copayment, and the Part B deductible may apply. Later, we'll discuss which preventive services require a copayment.



Medicare covers many preventive services to help you stay healthy. Talk to your health care provider about which of these services are right for you.



The "Welcome to Medicare" preventive visit, also called the "Initial Preventive Physical Examination" (IPPE), is a great way to get up-to-date information on important screenings and vaccines and to review your medical history. It's only offered one time within the first 12 months of getting Medicare Part B.

During your preventive visit, your doctor or health care provider will perform the following services:

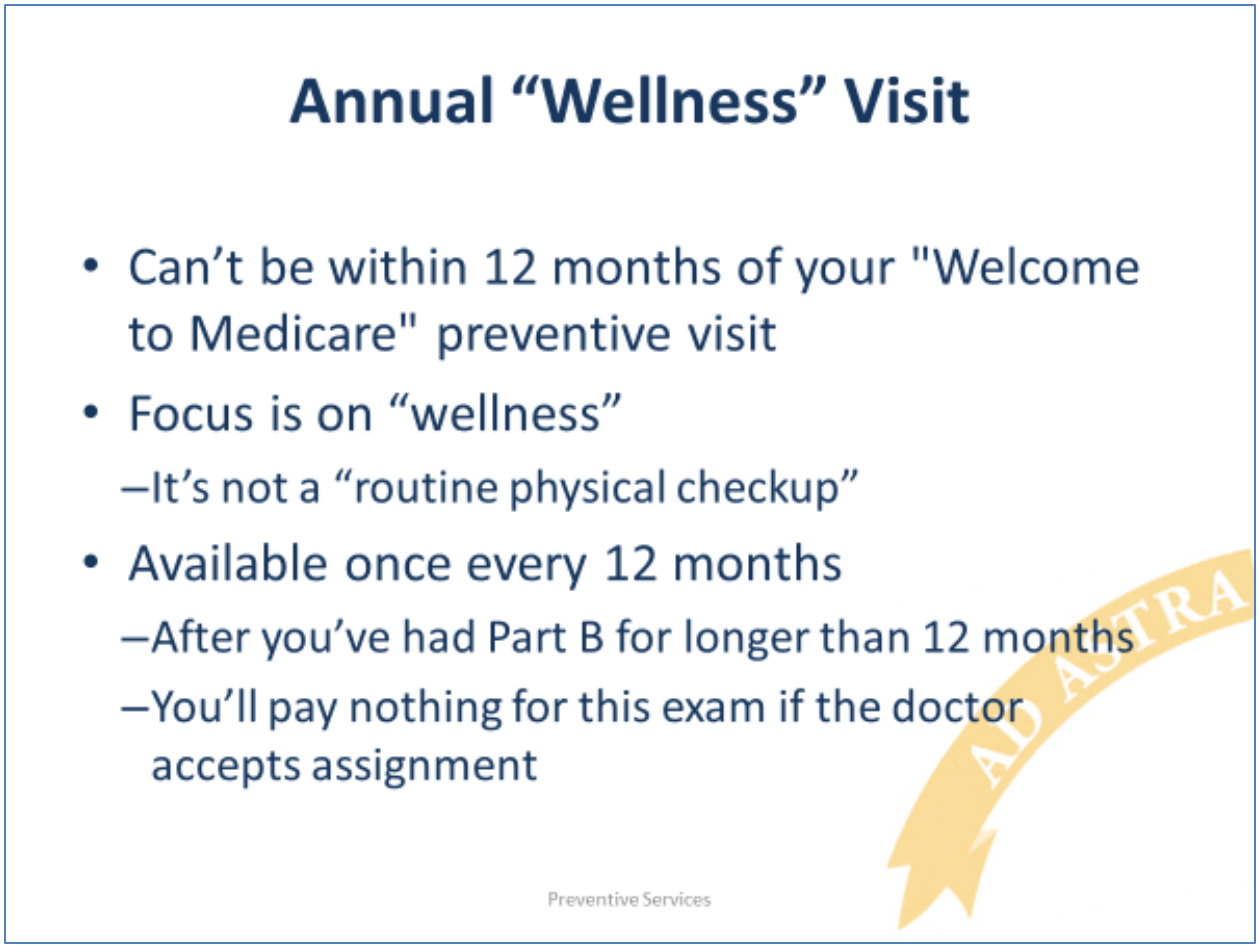
- Review your medical and social history
- Take your blood pressure, height, weight, and body mass index
- Perform a simple vision test
- Review potential risk factors for depression
- Review functional ability and level of safety, which means an assessment of hearing impairment, ability to successfully perform activities of daily living, fall risk, and home safety

You'll get advice to help you prevent disease, improve your health, and stay well. You'll also get a brief written plan (like a checklist), letting you know which screenings and other preventive services you need.

There is no cost if your doctor accepts Medicare assignment.

IMPORTANT: This service is a preventive visit and **not** a routine physical checkup. The "Welcome to Medicare" preventive visit doesn't include any clinical lab tests.

For more information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf.



After you’ve had Part B for longer than 12 months, you can get an annual "Wellness" visit to develop or update a prevention plan just for you. Medicare covers one annual “Wellness” visit every 12 months.

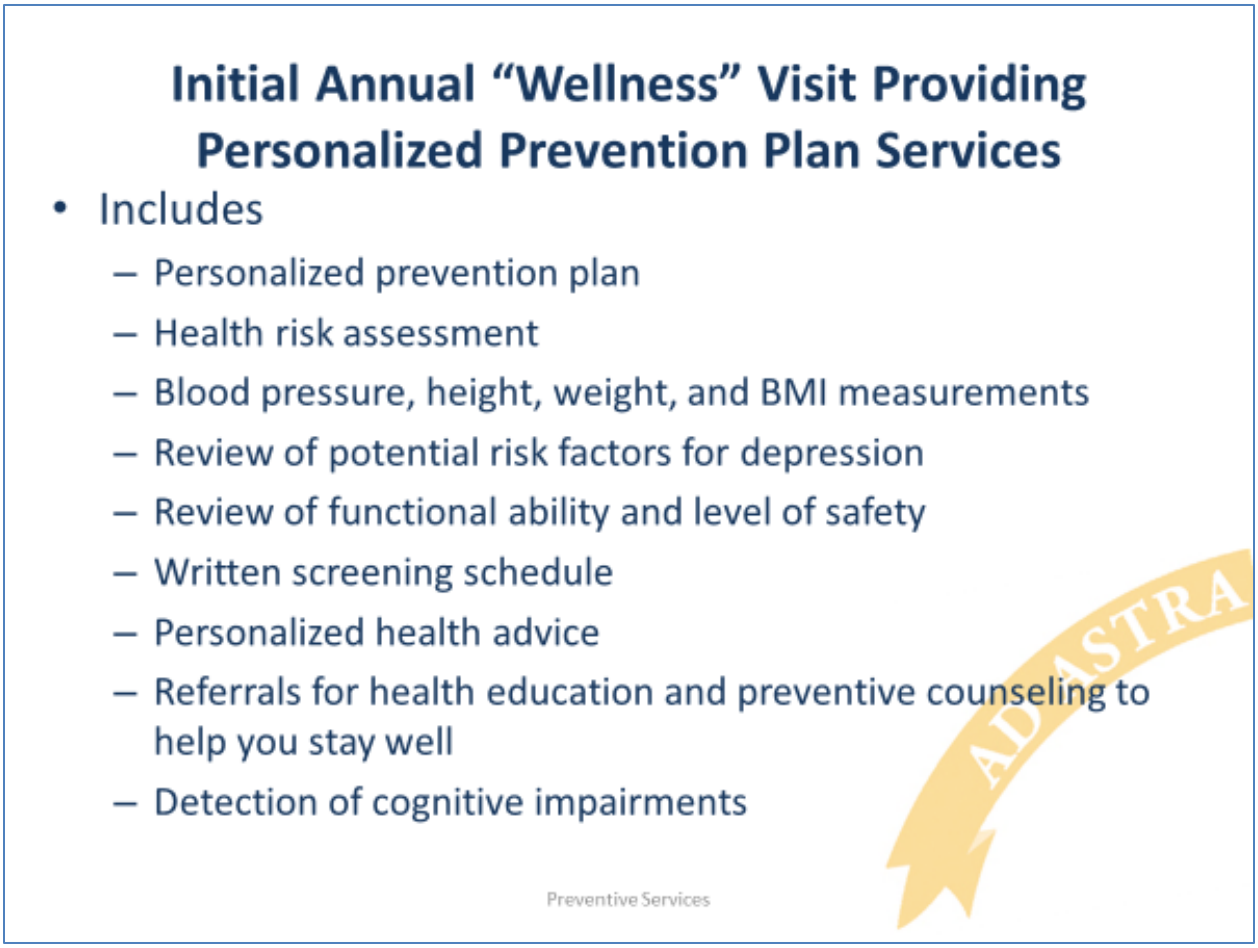
You don’t need to get the “Welcome to Medicare” preventive visit before getting an annual "Wellness" visit. If you got the “Welcome to Medicare” preventive visit, you’ll have to wait 12 months before you can get your first annual “Wellness” visit.

Medicare will cover an annual “Wellness” visit at no cost to you. You can work with your doctor to develop and update your personalized prevention plan. This benefit provides an ongoing focus on prevention that can be adapted as your health needs change over time.

You’ll pay nothing for this exam if the doctor accepts assignment.

IMPORTANT: The annual "Wellness" visit isn’t a routine physical checkup.

For more information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf.



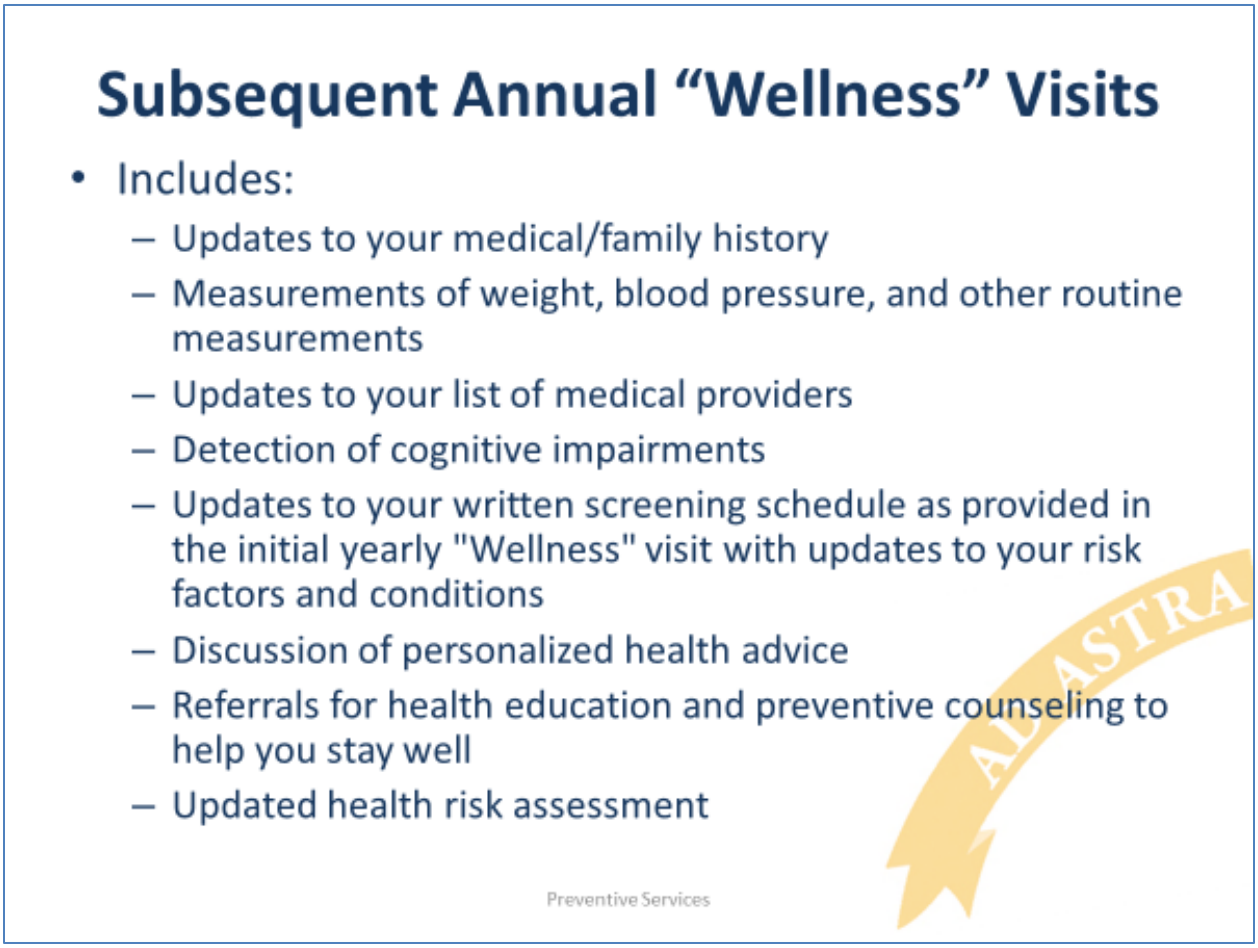
If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop a personalized plan to help prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

Your health professional will ask you to answer some questions before your visit. This is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your initial "Wellness" visit and all subsequent yearly "Wellness" visits.

During the initial visit, your health care professional will

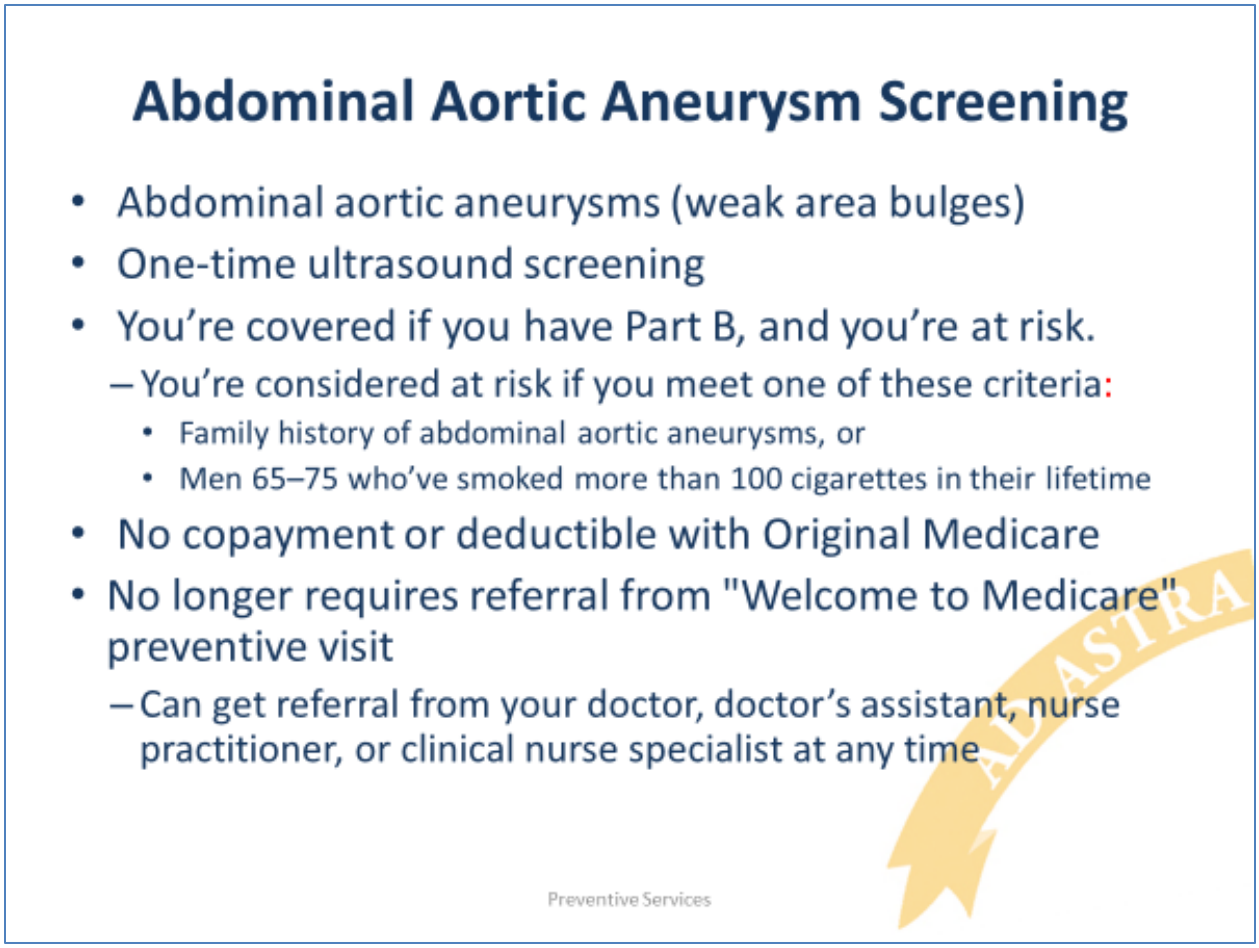
- Record your blood pressure, height, and weight measurements
- Review your potential risk factors for depression
- Review your functional ability and level of safety, which includes assessing your
- Hearing
- Ability to successfully perform activities of daily living (like walking, eating, etc.)
- Fall risk
- Home safety

You'll also receive advice to help you prevent disease, improve your health, and stay well. You'll get a brief written plan, like a checklist, letting you know which screenings and other preventive services you'll need over the next 5 to 10 years.



Subsequent annual "Wellness" visits providing personalized prevention plan services (PPPS) include the following:

- Updates to your medical/family history
- Measurements of your weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on your medical and family history
- Updates to the list of your current medical providers and suppliers that are regularly involved in your medical care, as was developed at the first yearly "Wellness" visit
- Detection of any cognitive impairment that you may have
- Updates to your written screening schedule as developed at the first yearly "Wellness" visit
- Updates to your list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for you, as was developed at your first yearly "Wellness" visit
- Discussion of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs
- An updated health risk assessment



Medicare Part B covers a one-time abdominal aortic aneurysm ultrasound. You must get a referral for it from your doctor.

The aorta is the largest artery in your body. It carries blood away from your heart. When it reaches your abdomen, it's called the abdominal aorta.

The abdominal aorta supplies blood to the lower part of the body. When a weak area of the abdominal aorta expands or bulges, it's called an abdominal aortic aneurysm (AAA). Aneurysms develop slowly over many years and often have no symptoms. If an aneurysm expands rapidly, tears open (ruptured aneurysm), or blood leaks along the wall of the vessel (aortic dissection), serious symptoms may suddenly develop.

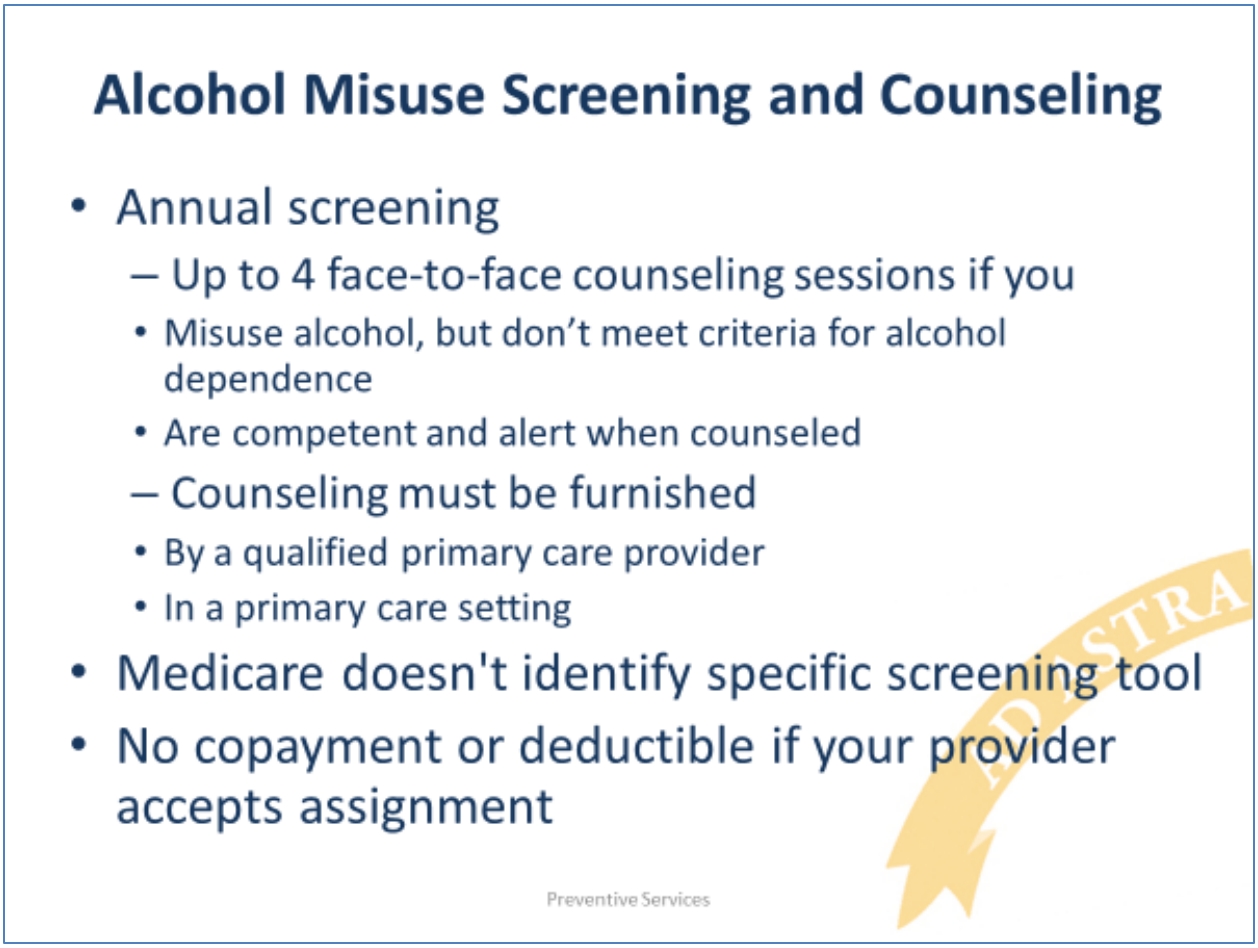
For a one-time screening ultrasound, you must get a referral from your doctor, doctor's assistant, nurse practitioner, or clinical nurse specialist.

You are considered at risk if any of the following apply to you:

- A family history of AAA
- You're a man 65 to 75 and have smoked at least 100 cigarettes in your lifetime
- You're a person with Medicare who has other risk factors in a category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

If any of these apply to you, Medicare covers ultrasound screening for abdominal aortic aneurysms with no deductible or copayment if the doctor accepts assignment.

For more information on risk factors, visit Healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm.

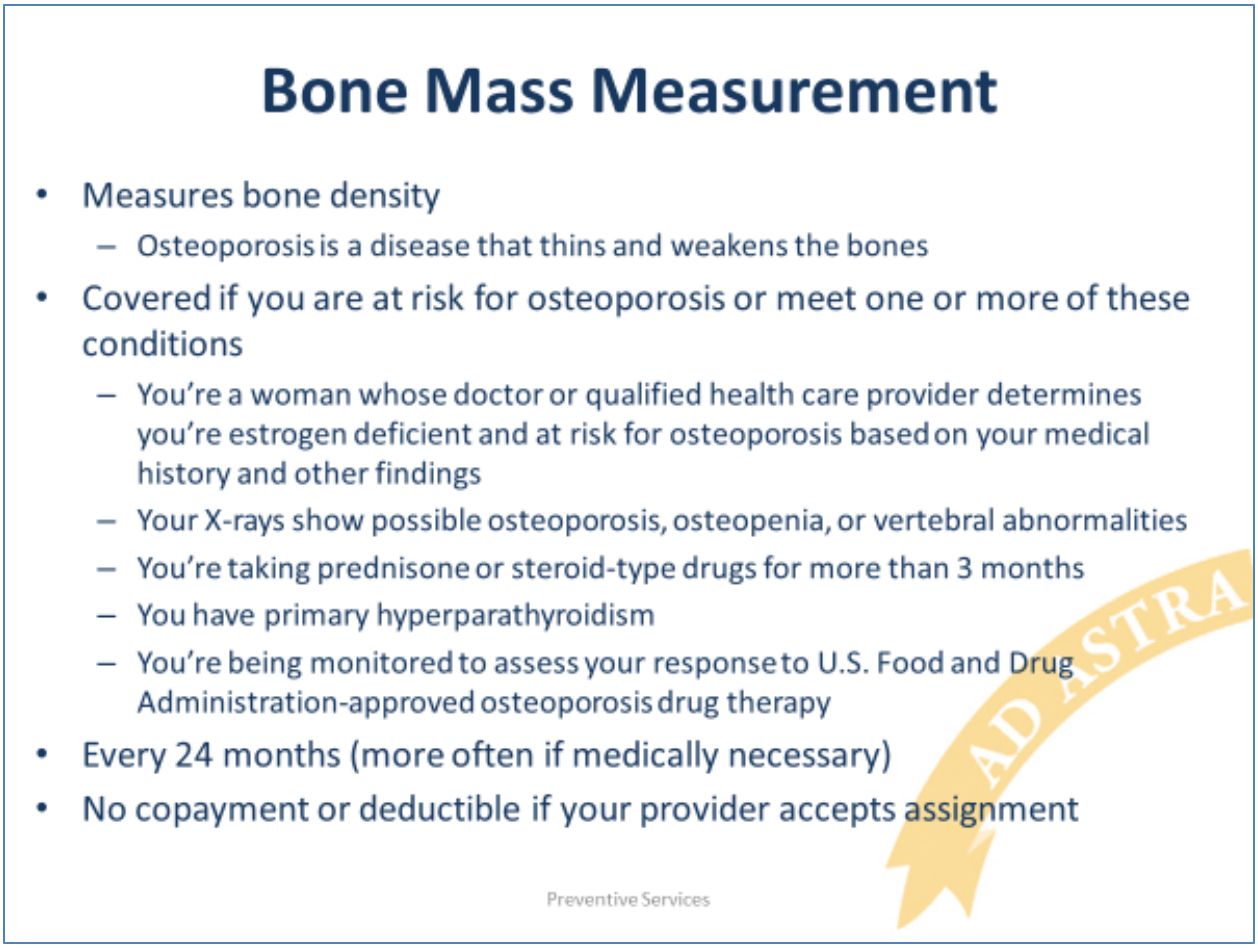


Medicare covers an annual alcohol misuse screening. Various screening tools are available to determine alcohol misuse. Medicare doesn't identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

For those who screen positive, Medicare covers up to 4 brief (15-minute), face-to-face behavioral counseling interventions per year for people with Medicare (including pregnant women) who meet the following requirements:

- Misuse alcohol, but whose levels or patterns of alcohol consumption don't meet criteria for alcohol dependence (defined as at least 3 of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition and/or use; persistent desire or unsuccessful efforts to quit; sustains social, occupational, or recreational disability; use continues despite adverse consequences)
- Are competent and alert at the time that counseling is provided
- Counseling is furnished by qualified primary care doctors or other primary care practitioners in a primary care setting

A primary care setting is defined as one in which there's provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices aren't considered primary care settings under this definition.



Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.

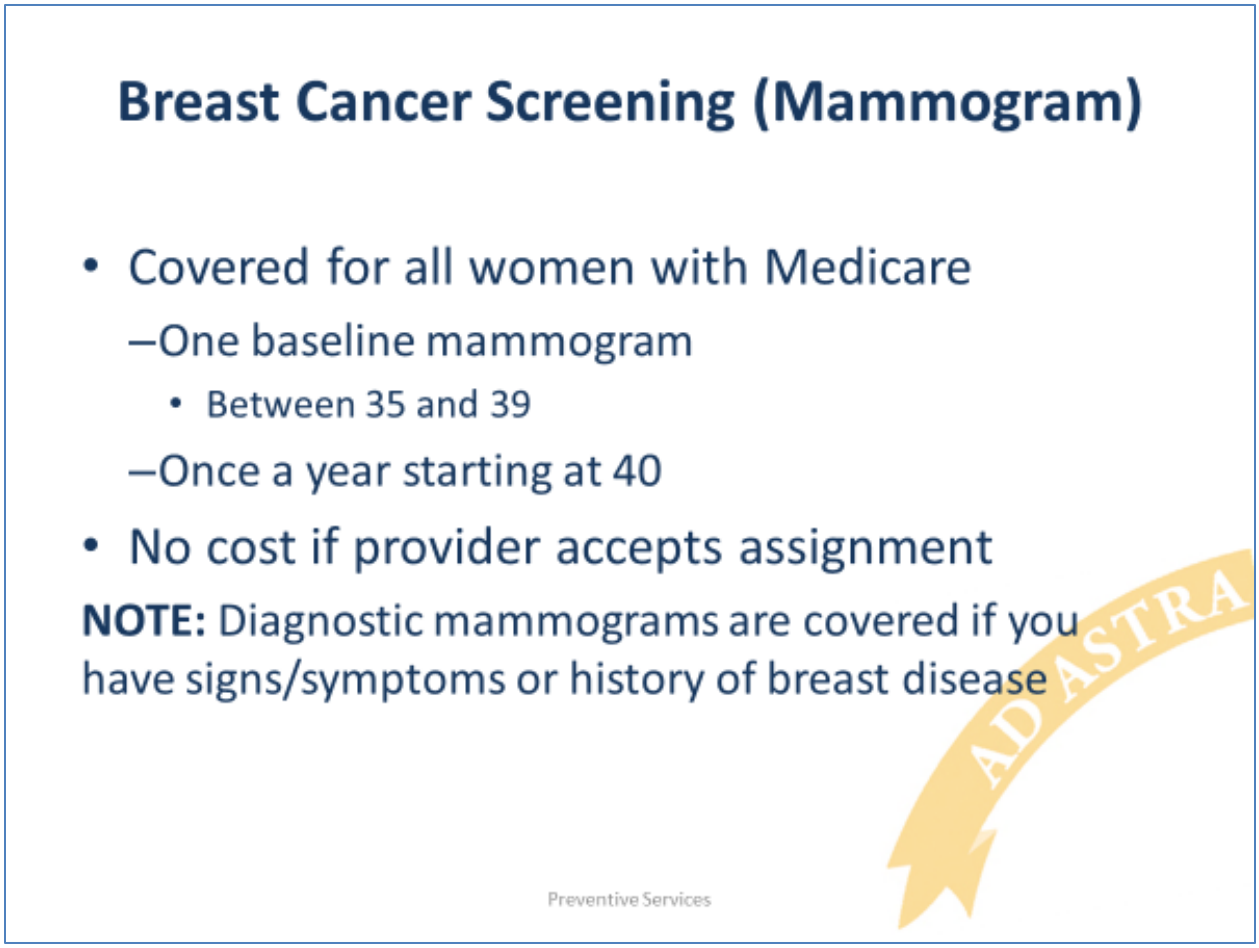
Osteoporosis is a disease in which your bones become weak and are more likely to break. It's a silent disease, meaning that you may not know you have it until you break a bone.

Bone mass measurement is covered once every 24 months, or more often if medically necessary, you are at risk for osteoporosis or meet one or more of these conditions:

- Women whose doctor or qualified health care provider determines she's estrogen-deficient and at risk for osteoporosis based on her medical history and other findings
- Individuals receiving (or expecting to receive) steroid therapy for more than 3 months
- Individuals with X-rays show possible osteoporosis, osteopenia, or vertebral abnormalities
- Individuals with primary hyperparathyroidism
- Individuals being monitored to assess their response to U.S. Food and Drug Administration-approved osteoporosis drug therapy

In Original Medicare, there's no cost if provider accepts assignment.

Resource: MedlinePlus medlineplus.gov/osteoporosis.html



Breast cancer is the most frequently diagnosed non–skin cancer in women, and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Every woman is at risk, and this risk increases with age.

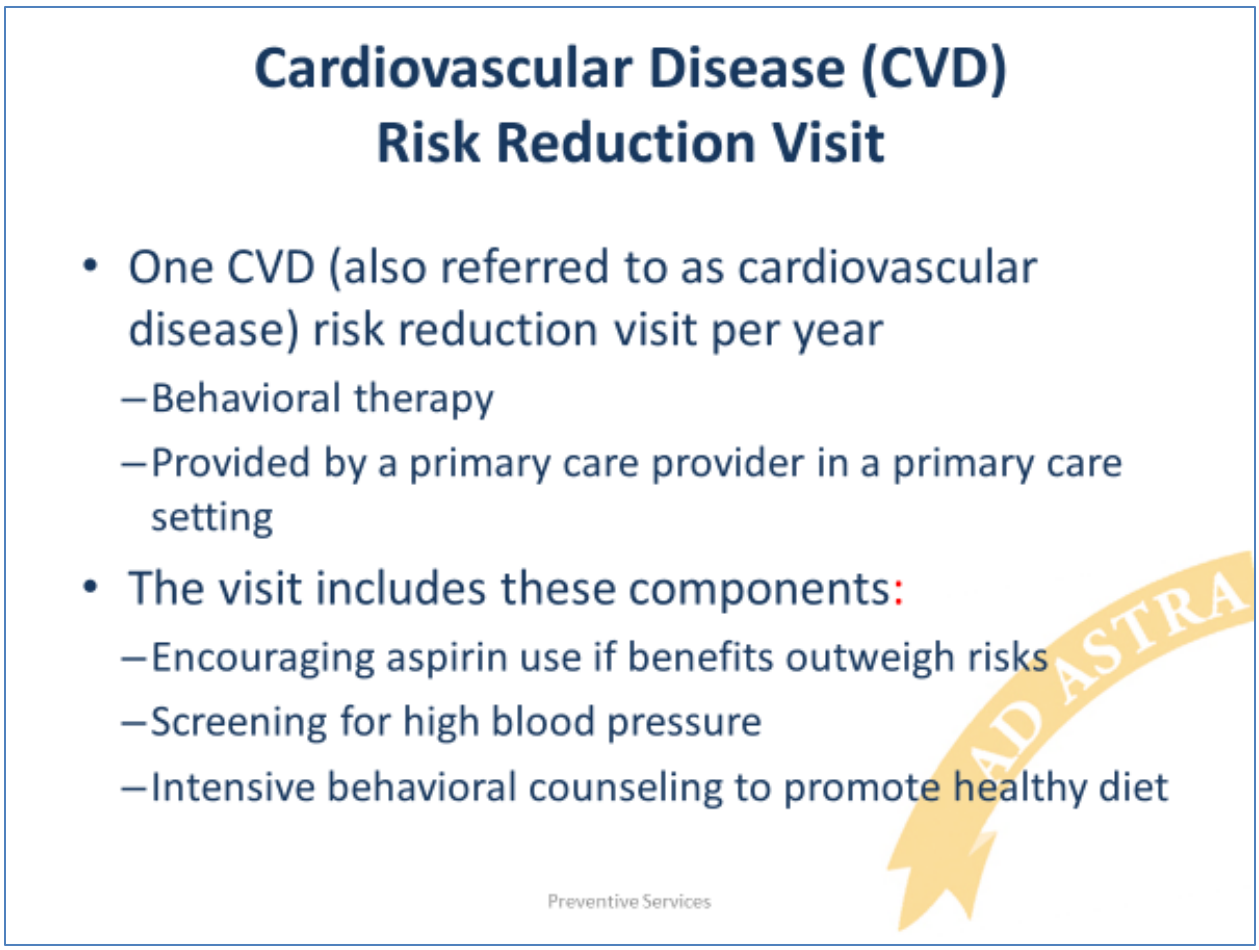
A screening mammogram is a radiologic procedure, an X-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease. The procedure includes a doctor's interpretation of the results.

Medicare provides coverage of an annual screening mammogram for women with Medicare who are 40 and older. Medicare also provides coverage of one baseline screening mammogram for women ages 35 through 39.

You don't need a doctor's referral, but the X-ray supplier will need to send your test results to a doctor.

In Original Medicare, there's no deductible or copayment if the doctor or qualified health care provider accepts assignment.

Diagnostic mammograms are done to check for breast cancer in men and women after a lump or other sign of breast cancer is found, if you have a history of breast cancer, or if your doctor judges by your history and other significant factors that a mammogram is appropriate. The coinsurance or copayment and the Part B deductible applies for diagnostic mammograms.



Medicare covers intensive behavioral therapy for cardiovascular disease (referred to as a CVD risk reduction visit).

Medicare covers one face-to-face CVD risk reduction visit per year for people with Medicare who are competent and alert at the time that counseling is provided. Counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting.

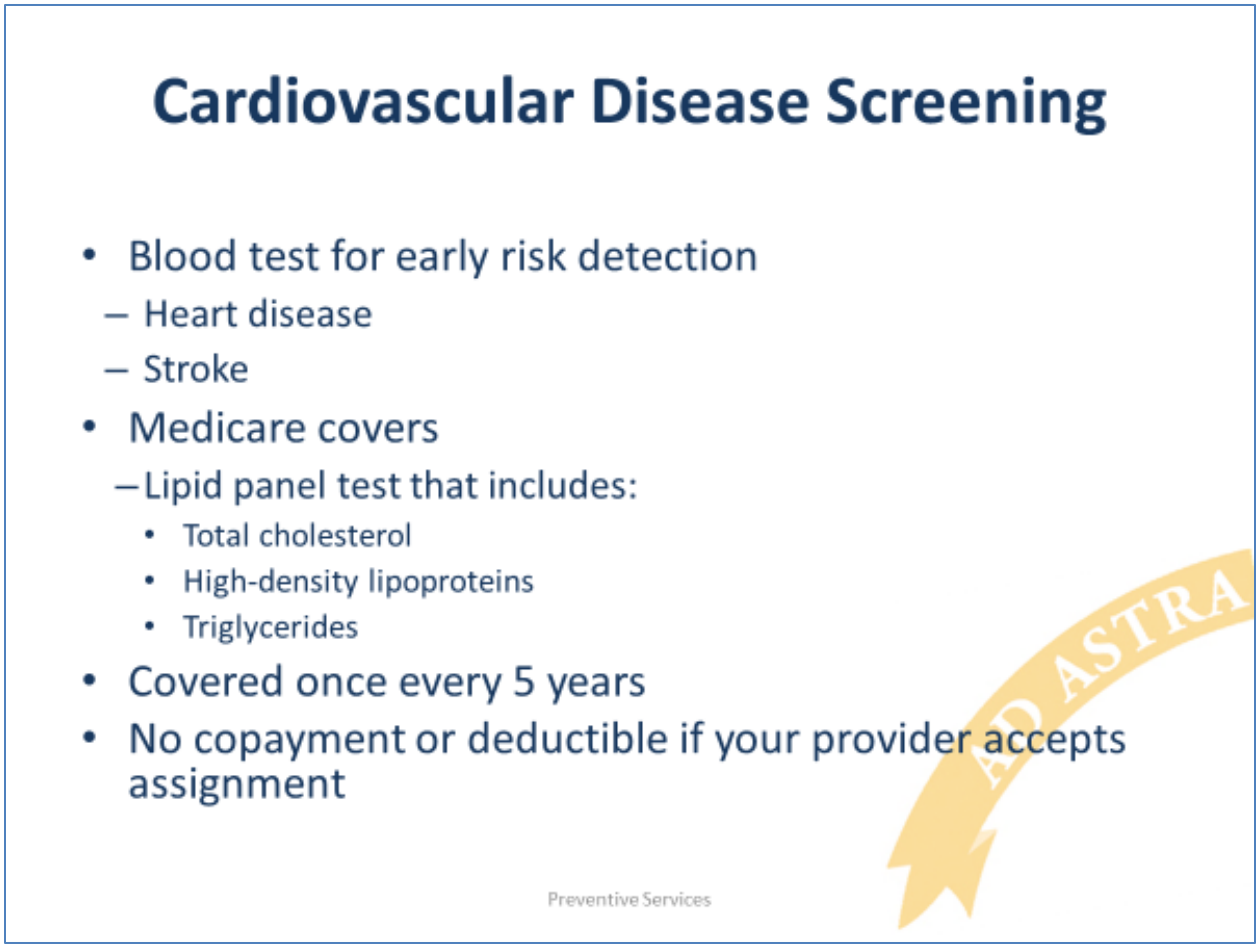
A primary care setting is defined as one in which there's a provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices aren't considered primary care settings under this definition.

The CVD risk reduction visit consists of these components:

Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men 45–79 and women 55–79

Screening for high blood pressure in adults 18 or older

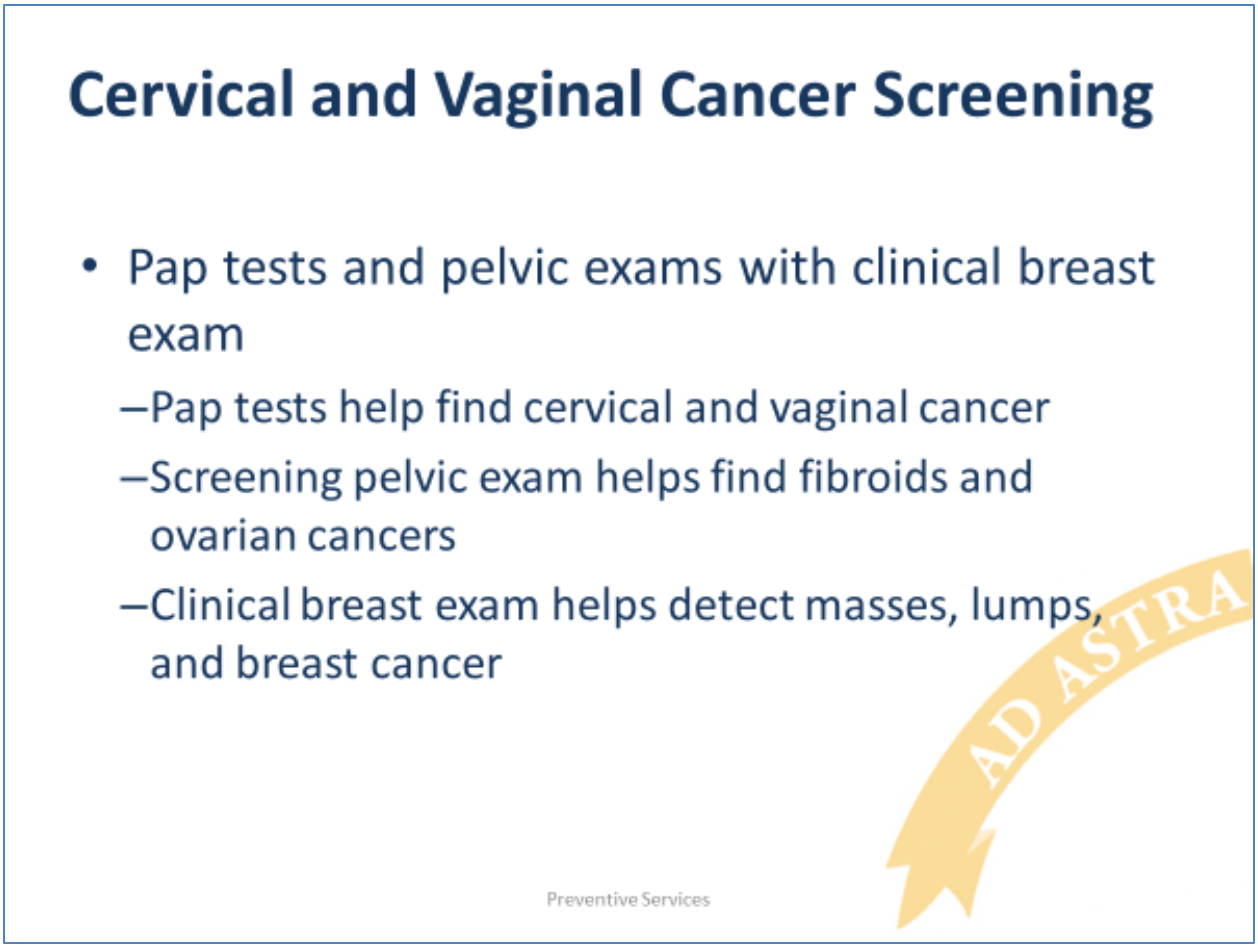
Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease



Medicare covers cardiovascular screening tests that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke.

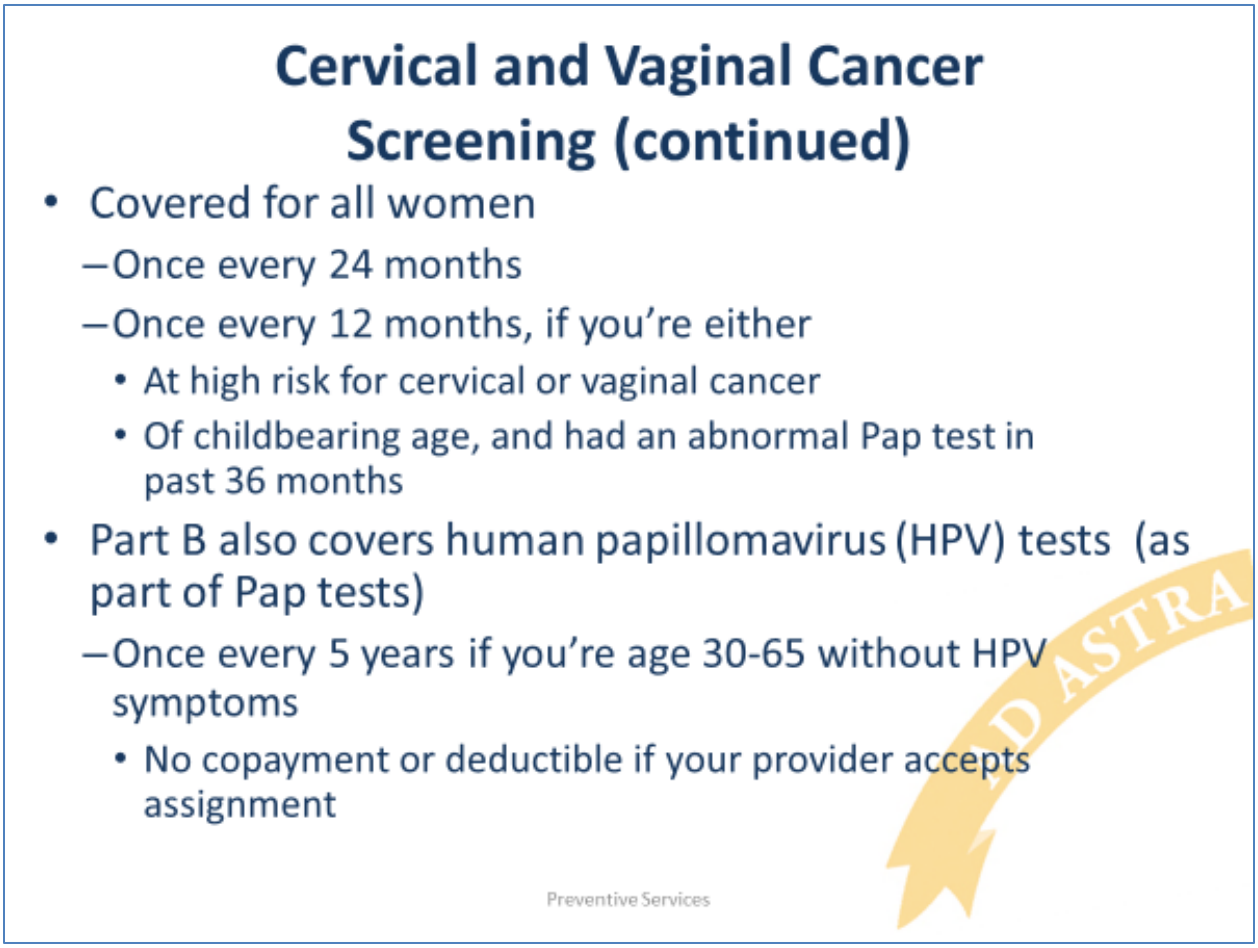
Lipid panel test that include total cholesterol, high-density lipoproteins (HDL) cholesterol, and triglyceride levels are covered once every 5 years for all people with Medicare who have no apparent signs or symptoms of cardiovascular disease.

In Original Medicare, there's no cost if the provider accepts assignment.



Medicare covers Pap tests (Papanicolaou test), pelvic exams, and clinical breast exams.

- The screening Pap test covered by Medicare is a laboratory test that consists of a routine exfoliative cytology test provided for the purpose of early detection of cervical cancer. It includes collection of a sample of cervical cells and a doctor's interpretation of the test.
- A screening pelvic examination is performed to help detect fibroids (benign tumors in women of childbearing age), pre-cancers, genital cancers, infections, sexually transmitted infections (STIs), other reproductive system abnormalities, and genital problems.
- In addition, a Medicare-covered screening pelvic examination includes a clinical breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer.



These tests are covered services for all women with Medicare, and will usually be performed during the same office visit. These services are covered once every 24 months for most women. However, they may be covered every 12 months if one of the following applies:

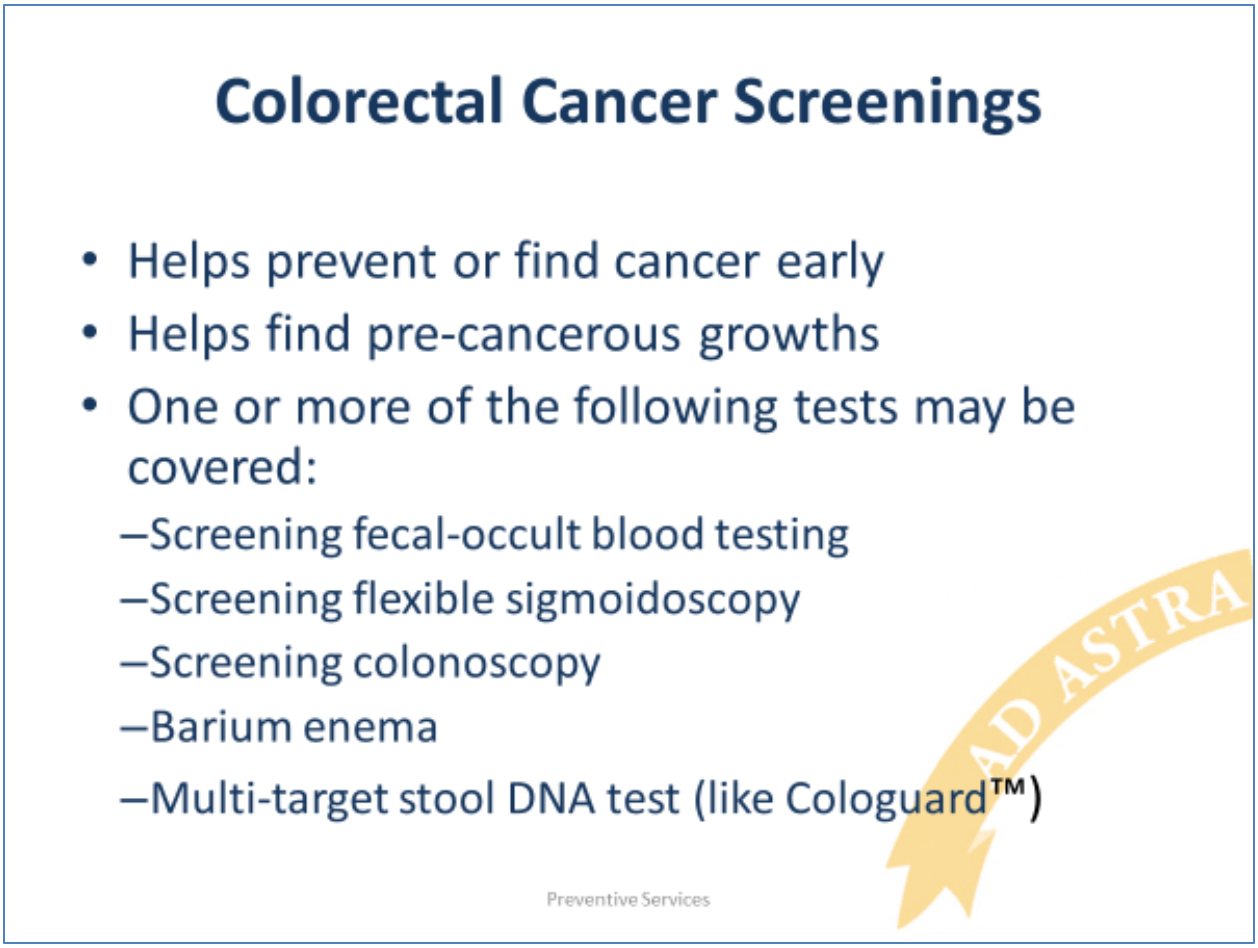
- You're at high risk for cervical or vaginal cancer (based on your medical history or other findings)
- You're of childbearing age, and had an abnormal Pap test in the past 36 months

High risk factors for cervical or vaginal cancer include the following:

- Early onset of sexual activity (under 16)
- Multiple sexual partners (5 or more in a lifetime)
- History of sexually transmitted disease (including human immunodeficiency virus)
- Fewer than 3 negative or no Pap tests within the previous 7 years
- DES (diethylstibestrol)-exposed daughters of women who took DES during pregnancy

Part B also covers human papillomavirus (HPV) tests (as part of Pap tests) once every 5 years if you're age 30–65 without HPV symptoms.

In Original Medicare, there's no cost if provider accepts assignment.



In the United States, colorectal cancer is the fourth most common cancer in men and women. If caught early, it's often curable.

To help find pre-cancerous growths and help prevent or find cancer early, when treatment is most effective, your doctor may order one or more of the following tests if you meet certain conditions: screening fecal occult blood test; screening flexible sigmoidoscopy, screening colonoscopy; barium enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy), or a multi-target stool DNA test (like Cologuard™).

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or polyps
- Family history of familial polyps
- Personal history of colorectal cancer
- Personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis
- For people with Medicare at high risk of developing colorectal cancer, the frequency of covered screening tests varies from the frequency of covered screenings for those not considered at high risk.

NOTE: If a polyp or other tissue is found and removed during a screening colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

Colorectal Cancer Screenings

Screening Test	If Normal Risk Covered Once Every	If High Risk, Covered Once Every	You Pay
Screening fecal-occult blood testing age 50 or older	12 months	12 months	No deductible or copayment for this test
Screening flexible sigmoidoscopy age 50 or older	4 years, or 10 years after a previous screening colonoscopy	4 years	No deductible or copayment for this test
Screening colonoscopy No minimum age	10 years (generally) or 4 years after a previous flexible sigmoidoscopy	24 months	No deductible or copayment for this test

Preventive Services

All people with Medicare age 50 and older who **aren't** at high risk for colorectal cancer are covered for the following screenings:

- Fecal-occult blood test every year
- Flexible sigmoidoscopy once every 4 years or 47 months have passed (unless a screening colonoscopy has been performed, and then Medicare may cover a screening sigmoidoscopy after 10 years or at least 119 months)
- Colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed, and then Medicare may cover a screening colonoscopy after at least 4 years have passed) (no minimum age)

All people with Medicare age 50 and older who are at high risk for colorectal cancer are covered for the following screenings:

- Fecal-occult blood test every year
- Flexible sigmoidoscopy once every 4 years (or 47 months have passed)
- Colonoscopy once every 2 years

People with Original Medicare don't pay a copayment or deductible for fecal occult blood tests, flexible sigmoidoscopy, and colonoscopy if the provider accepts assignment.

NOTE: If during the course of a screening colonoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, this becomes a diagnostic procedure (G0105). The procedure may be subject to a copayment and/or coinsurance.

Colorectal Cancer Screenings (continued)

Screening Test	If Normal Risk, Covered Once Every	If High Risk, Covered Once Every	You Pay
Barium enema age 50 or older	4 years when used instead of a flexible sigmoidoscopy or colonoscopy	24 months (as an alternative to a covered screening colonoscopy or flexible sigmoidoscopy)	There is no deductible for this test. You pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.
Multi-target Stool DNA test (like Cologuard™)	3 years	3 years	There is no deductible or copayment for this test.

Preventive Services

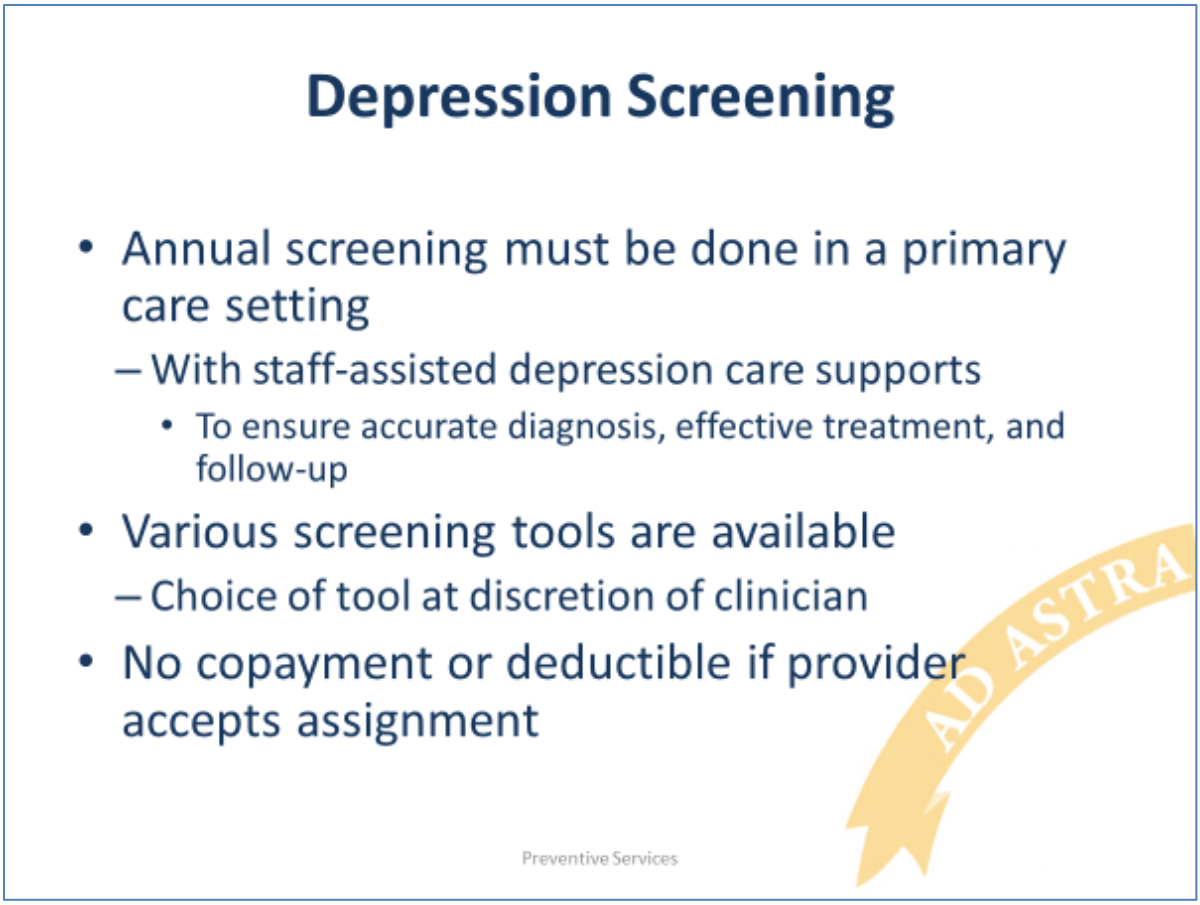
All people with Medicare age 50 and older who **aren't** at high risk for colorectal cancer are covered for the following screenings:

- Barium enema every 4 years when used instead of a sigmoidoscopy or colonoscopy
- Multi-target stool DNA test (like Cologuard™) every 3 years

All people with Medicare age 50 and older who are at high risk for colorectal cancer are covered for the following screenings:

- Barium enema every 24 months as an alternative to a covered screening colonoscopy
- Multi-target stool DNA test (like Cologuard™)

People with Original Medicare don't pay a deductible for a screening barium enema, if the provider accepts assignment; however, you pay the Medicare-approved amount for the doctor's services. In a hospital setting, you pay a copayment. There is no deductible or copayment for the multi-target stool DNA test.



Medicare covers an annual screening for depression (up to 15 minutes) for people with Medicare in primary care settings that have staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up.

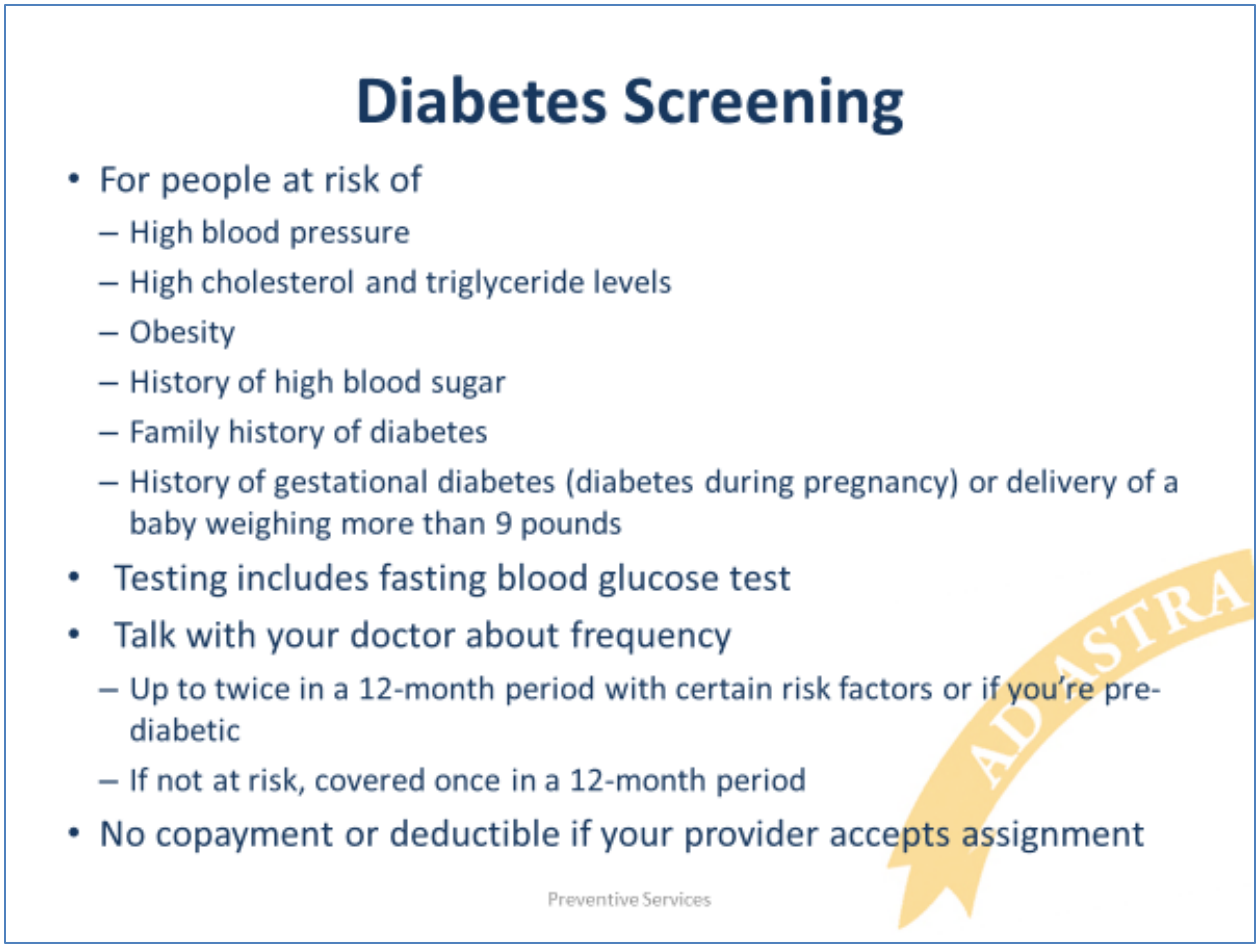
Various screening tools are available for screening for depression. CMS doesn't identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

Coverage is limited to screening services and doesn't include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression. Furthermore, the depression screening doesn’t address therapeutic interventions such as pharmacotherapy (treatment with drugs), combination therapy (counseling and medications), or other interventions for depression.

Among people older than 65, one in 6 suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. It's estimated that 50–75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39% were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are limited to: feeling sad or empty, less interest in daily activities, weight loss or gain when not dieting, less ability to think or concentrate, tearfulness, feelings of worthlessness, and thoughts of death or suicide.

You pay nothing for this test if the doctor or other qualified health care provider accepts assignment. If you get the depression screening and another service, you may need to pay 20% of the Medicare-approved amount for the other service and the Part B deductible may apply.



Diabetes is a disease in which your blood glucose, or sugar levels, are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy.

With Type 1 diabetes, your body doesn't make insulin. With Type 2 diabetes, the more common type of diabetes, your body doesn't make or use insulin well. Without enough insulin, the glucose stays in your blood.

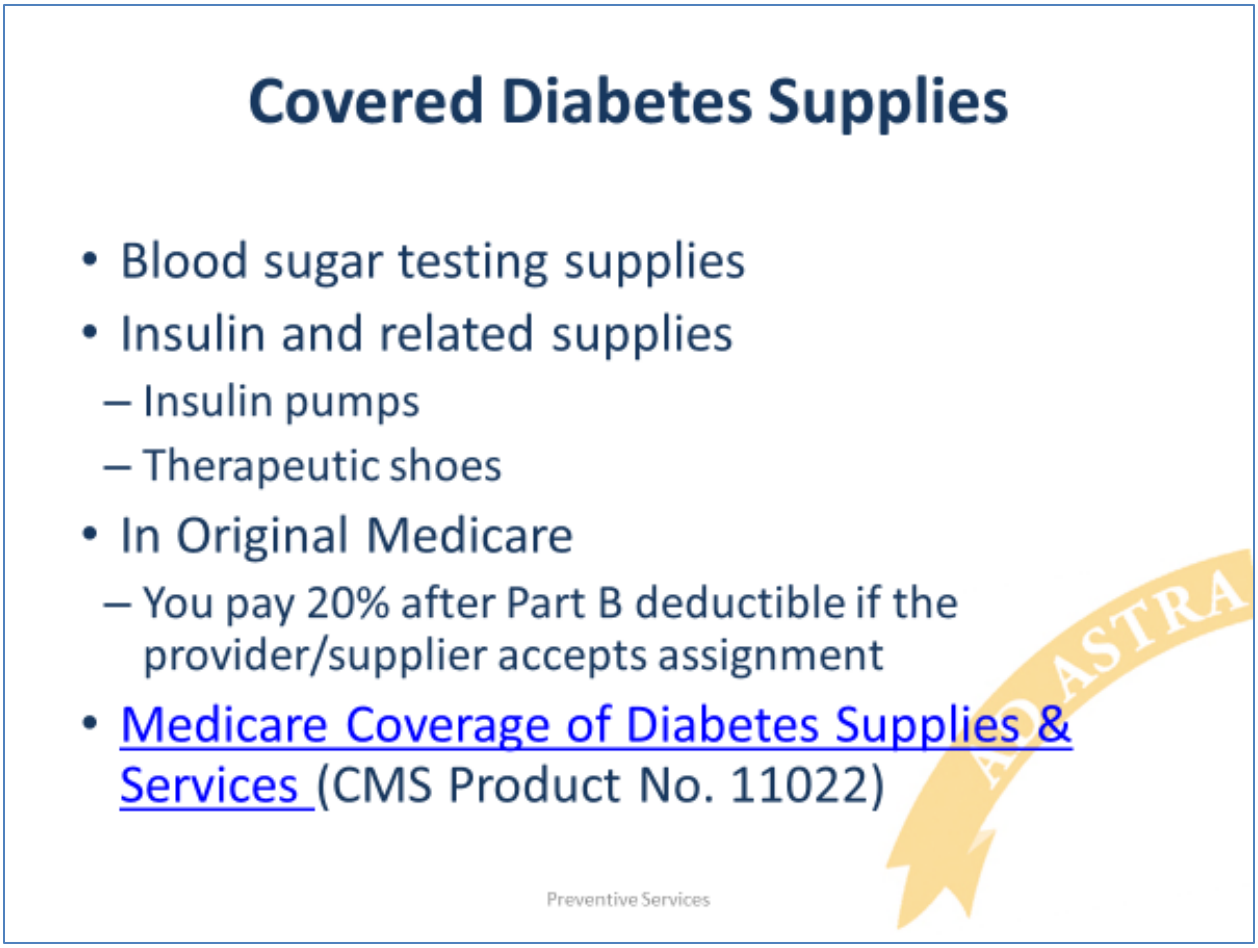
Over time, having too much glucose in your blood can cause serious problems. It can damage your eyes, kidneys, and nerves. Diabetes is the leading cause of acquired blindness among adults in the United States. Diabetes can also cause heart disease, stroke, and even the need to remove a limb. Pregnant women can also get diabetes, called gestational diabetes.

Other people at risk are those with high blood pressure, high cholesterol and triglyceride levels, obesity, history of high blood sugar, and a family history of diabetes.

Medicare covers diabetes screenings for all people with Medicare with certain risk factors for diabetes or diagnosed with pre-diabetes. The diabetes screening test includes a fasting blood glucose test.

Talk with your doctor about how often you should get tested. For people with pre-diabetes, Medicare covers a maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart). For people without diabetes, who've not been diagnosed as pre-diabetic or who've never been tested, Medicare covers one diabetes screening test within a 12-month period. A normal fasting blood sugar level is 100 mg/dL. Diabetes diagnosis occurs at 126 mg/dL, and a person with blood sugar readings between 101–125 mg/dL is considered pre-diabetic.

Medicare provides coverage for diabetes screenings as a Medicare Part B benefit after a referral from a doctor or qualified non-doctor practitioner for an individual at risk for diabetes. You pay nothing for this screening if the provider accepts assignment.



Medicare Part B covers some diabetes supplies, including insulin pumps, special foot care, and therapeutic shoes for people with diabetes who need them.

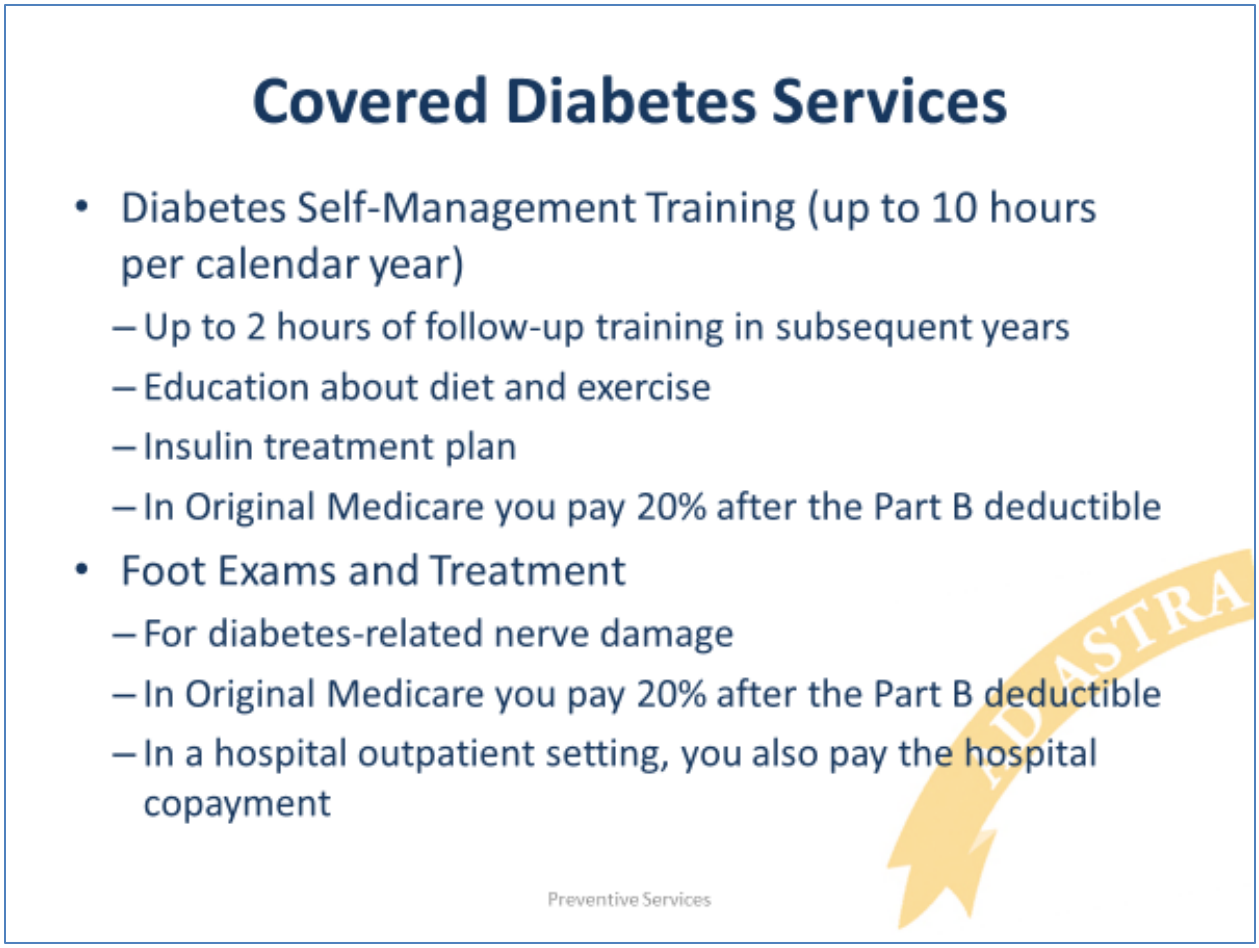
Insulin associated with an insulin pump is covered by Medicare Part B. Injectable insulin not associated with the use of an insulin pump is covered under Medicare prescription drug coverage (Part D).

In Original Medicare, you pay 20% of the Medicare-approved amount after the yearly Part B deductible for a glucometer, lancets, and test strips.

Medicare provides coverage for diabetes-related durable medical equipment (DME) and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier doesn't accept assignment, the amount you pay may be higher. In this case, Medicare will provide you with payment of the Medicare-approved amount.

Continuous glucose monitors (CGMs) monitor a patient's glucose level on a continuous basis (for example, every 5 minutes). Some therapeutic CGMs approved by the FDA are considered DME if used to replace a blood glucose monitor for use in making diabetes treatment decisions. For more information see CMS Ruling-1682-R dated January 12, 2017, at CMS.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf.

For more information, please review Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022) at Medicare.gov/Pubs/pdf/11022-Medicare-Diabetes-Coverage.pdf.



Medicare provides coverage of diabetes self-management training for people with Medicare who've recently been diagnosed with diabetes, were determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible under Medicare.

Medicare Part B covers up to 10 hours of diabetes outpatient self-management training during a calendar year. It includes education about how to monitor your blood sugar, diet, exercise, and medication. You must get an order from your doctor or qualified provider who's treating your diabetes.

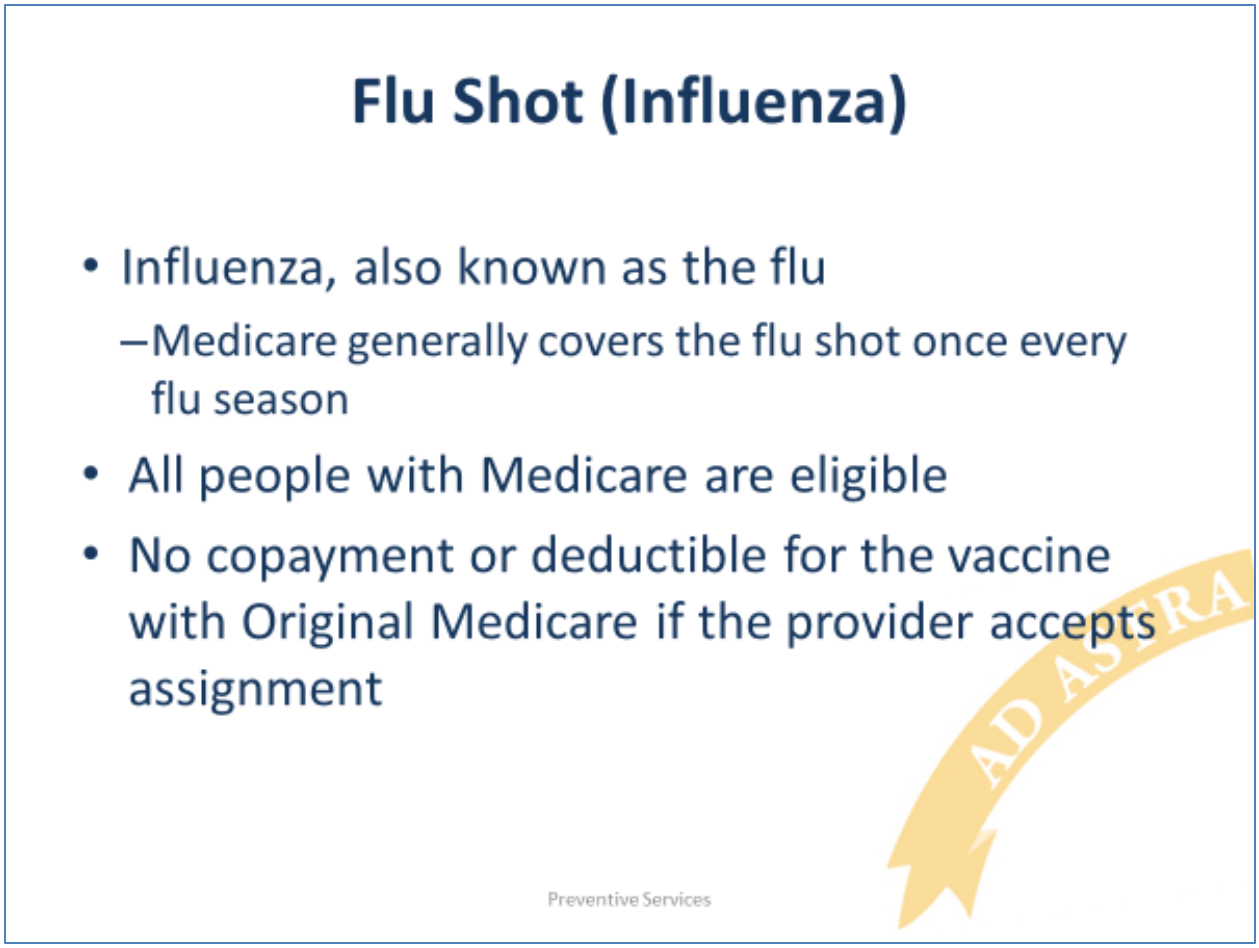
Each session lasts for at least 30 minutes and is provided in a group of 2 to 20 people.

Exception: You can get individual sessions if no group session is available, or if your doctor or qualified provider says you have special needs that would prevent you from participating effectively in group training.

You may also qualify for up to 2 hours of follow-up training each year if any of the following apply:

- Your doctor or a qualified provider ordered it as part of your plan of care
- It takes place in a calendar year after the year you got your initial training
- The Medicare Part B deductible and coinsurance or copayment apply. Some providers must accept assignment.

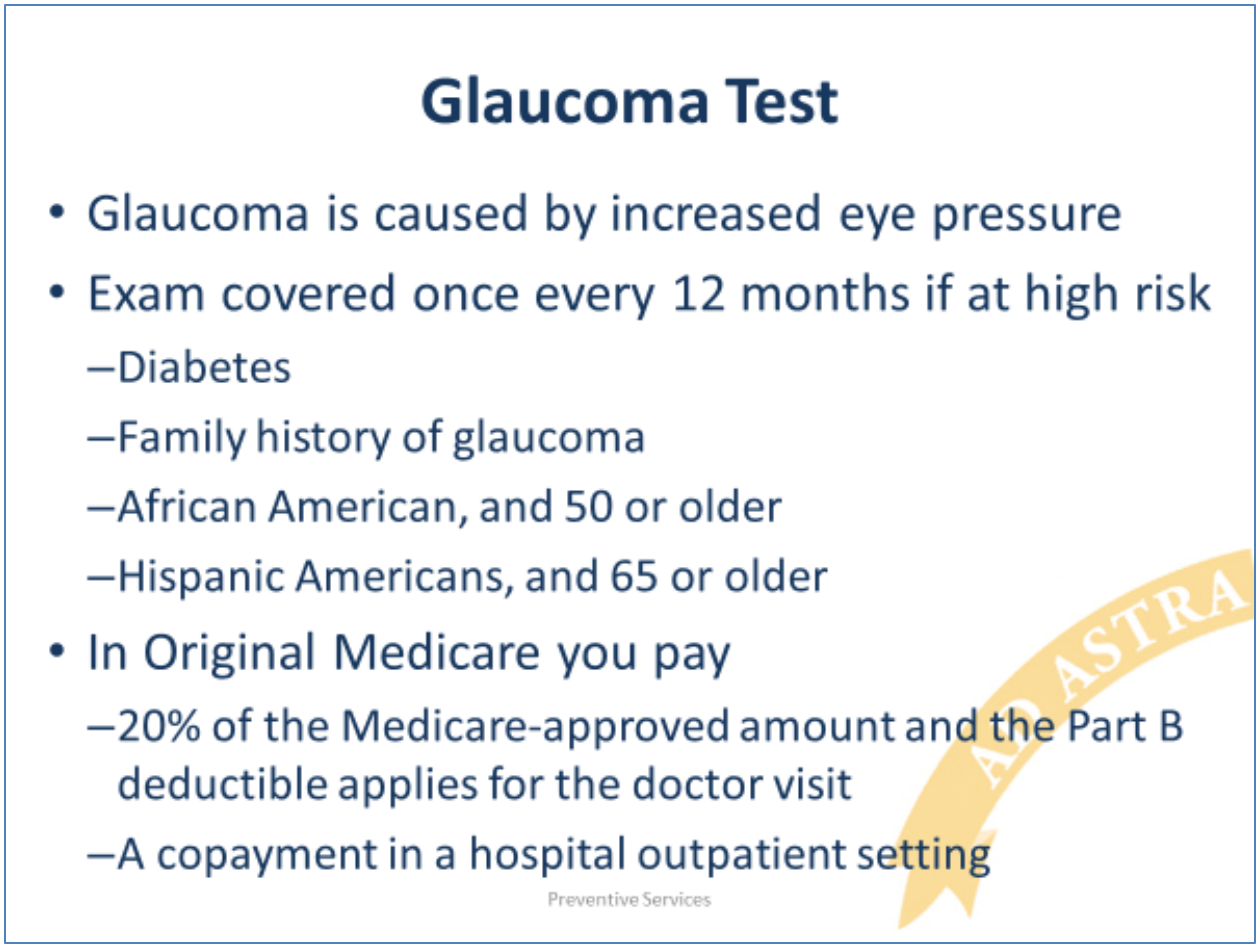
Medicare also covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.



Influenza, also known as the flu, is a contagious disease caused by influenza viruses that generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza can lead to pneumonia.

Medicare Part B provides coverage of one seasonal flu shot per flu season for all people with Medicare. This may mean that people with Medicare may receive more than one seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a doctor determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. For example, if someone gets a flu shot late in the flu season in January 2019, he or she will also be covered if he or she receives a shot in October, November, or December of 2019 because that is the start of a new flu season.

You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.



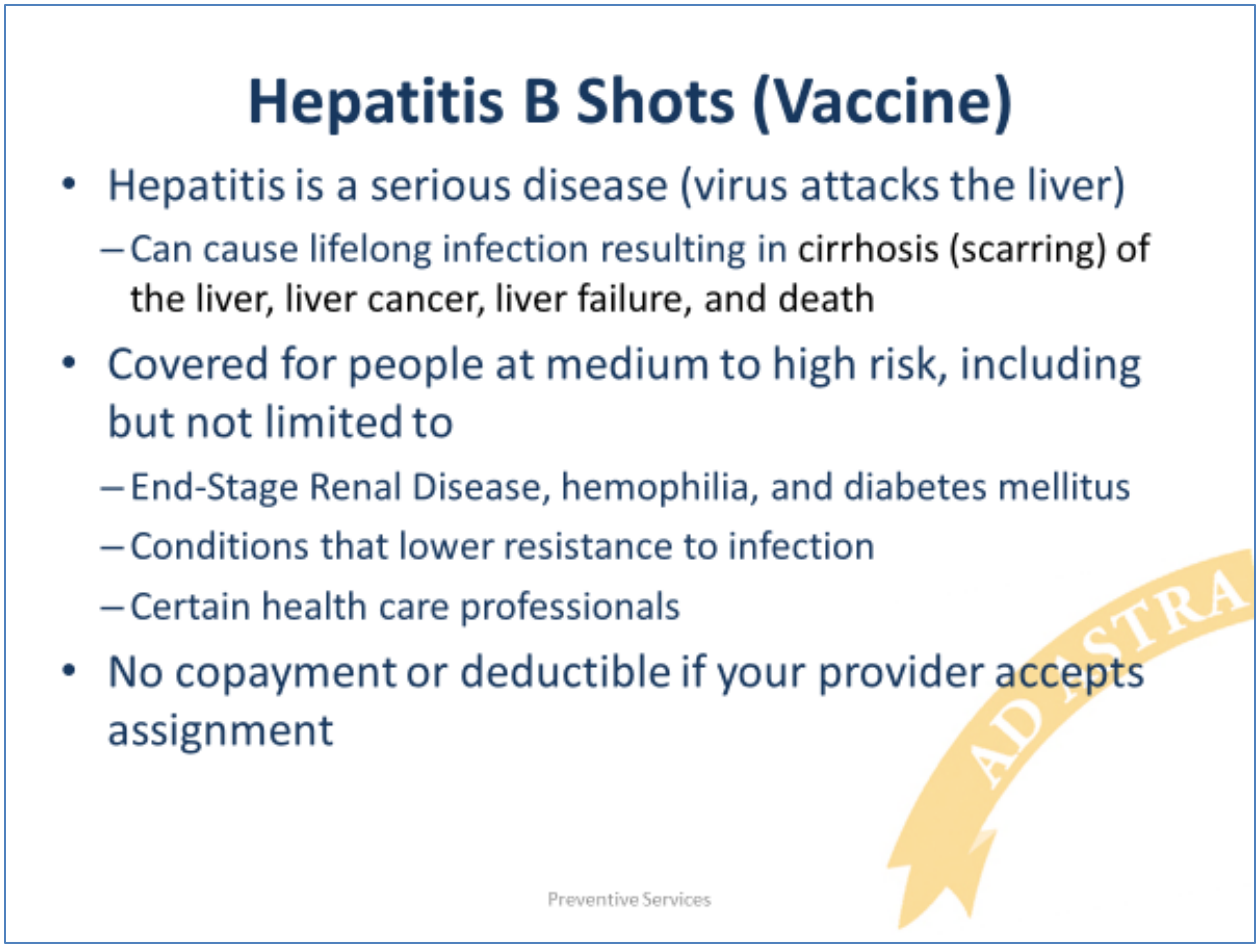
Glaucoma is an eye disease caused by above-normal pressure in the eye. It usually damages the optic nerve and you may gradually lose sight without symptoms. It can result in blindness, especially without treatment. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

You are considered high risk for glaucoma and eligible for Medicare coverage of the glaucoma test if any of the following apply:

- You have diabetes
- You have a family history of glaucoma
- You are African American, and 50 or older
- You are Hispanic Americans, and 65 or older

An eye doctor who's legally authorized by the state must perform the test. You pay 20% of the Medicare-approved amount and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, you pay a copayment.

NOTE: Medicare doesn't provide coverage for routine eye refractions.



Hepatitis B is a serious disease caused by the Hepatitis B virus (HBV). The virus can affect people of all ages. Hepatitis B attacks the liver and can cause chronic (lifelong) infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Medicare provides coverage for the Hepatitis B vaccine (series of shots) and its administration for people with Medicare at intermediate or high risk of contracting HBV.

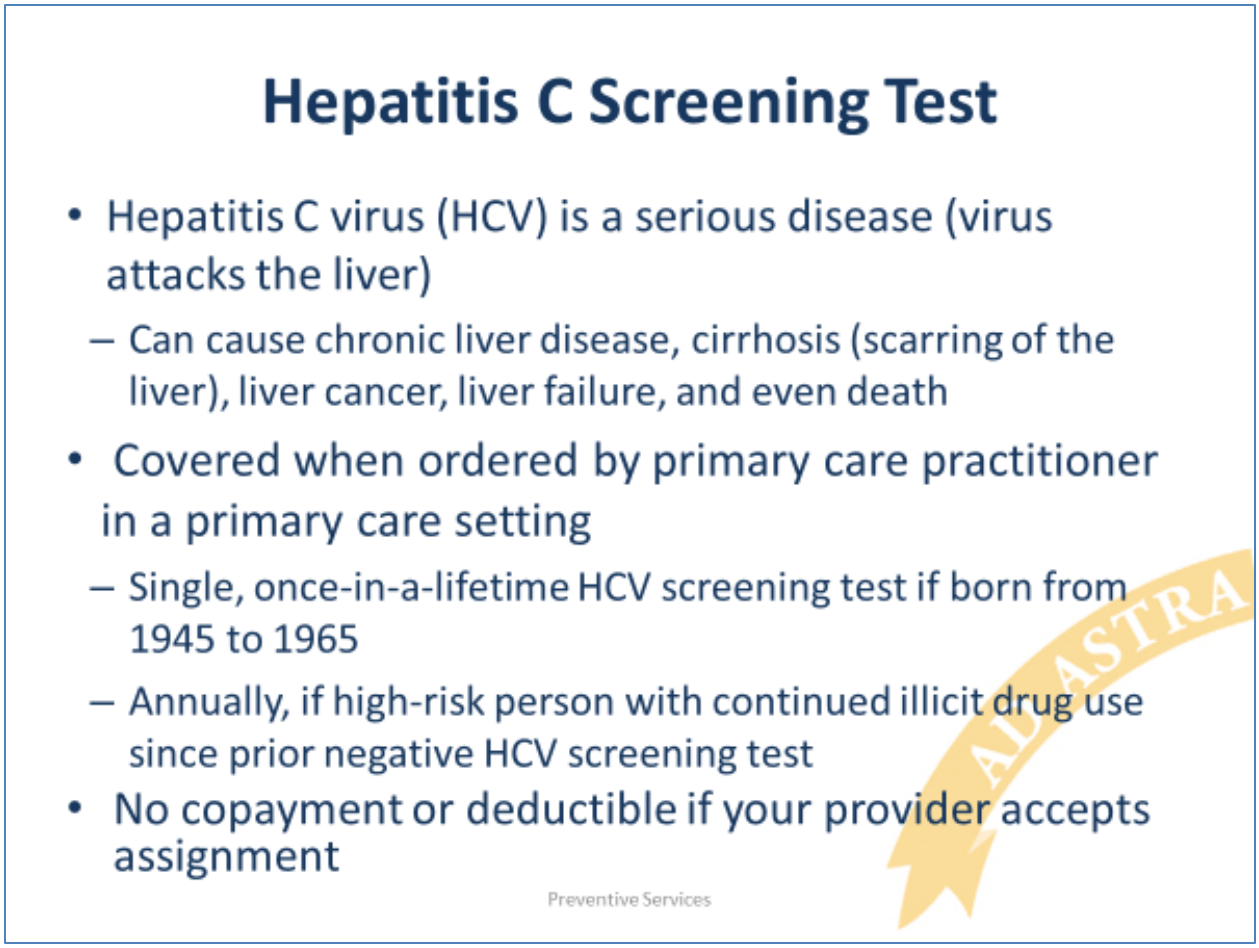
High-risk groups currently identified include the following:

- Individuals with End-Stage Renal Disease (ESRD)
- Individuals with hemophilia who received Factor VIII or IX
- Individuals with diabetes mellitus
- Clients of institutions for the developmentally disabled
- Individuals who live in the same household as an HBV carrier
- Men who have sex with men
- Illicit injectable drug users

Intermediate risk groups currently identified include the following:

- Staff in institutions for the developmentally disabled
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work

People with Original Medicare don't pay a copayment or deductible for this vaccine if their providers accept assignment.



Hepatitis C virus (HCV) is an infection that attacks the liver, and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal liver functions, which leads to liver failure. Cirrhotic livers are more prone to become cancerous, and liver failure leads to serious complications, even death.

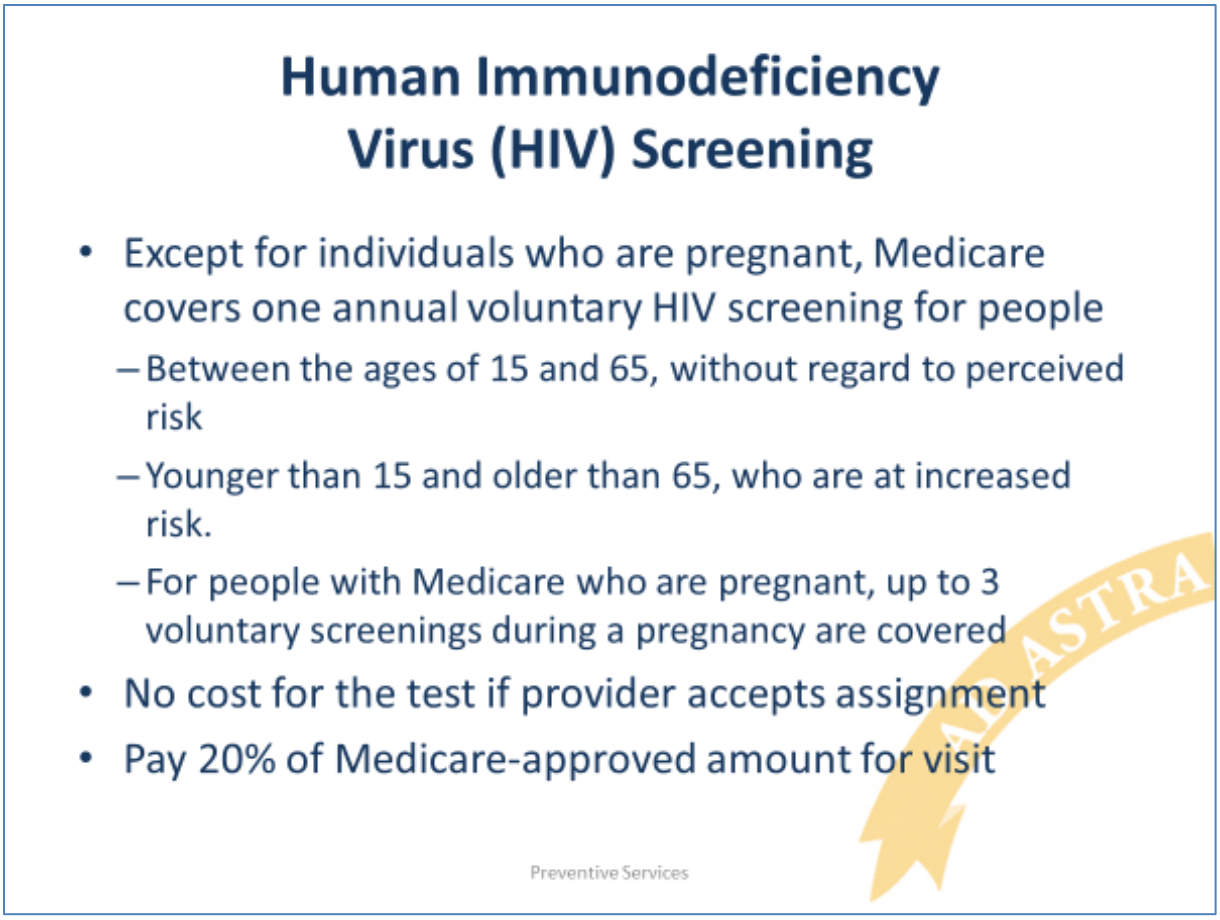
This screening is covered when ordered by the primary care practitioner within the context of a primary care setting for people with Medicare who meet either of the following conditions:

A single once-in-a-lifetime screening test is covered for adults who don't meet the high-risk determination, and were born from 1945 through 1965.

Repeat screening for high-risk persons is covered annually only for people who've had continued illicit injection drug use since the prior negative screening test.

The determination of "high risk for HCV" is identified by the primary care doctor or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual "Wellness" visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment. Medicare will only cover Hepatitis C screening tests if they're ordered by a primary care doctor or practitioner.



Human immunodeficiency virus (HIV) is the virus that causes AIDS. HIV attacks the immune system by destroying a type of white blood cell that is vital to fighting off infection. Once infected, it may take years for recognizable illness to develop. A person may be infected with HIV for years before the condition is suspected.

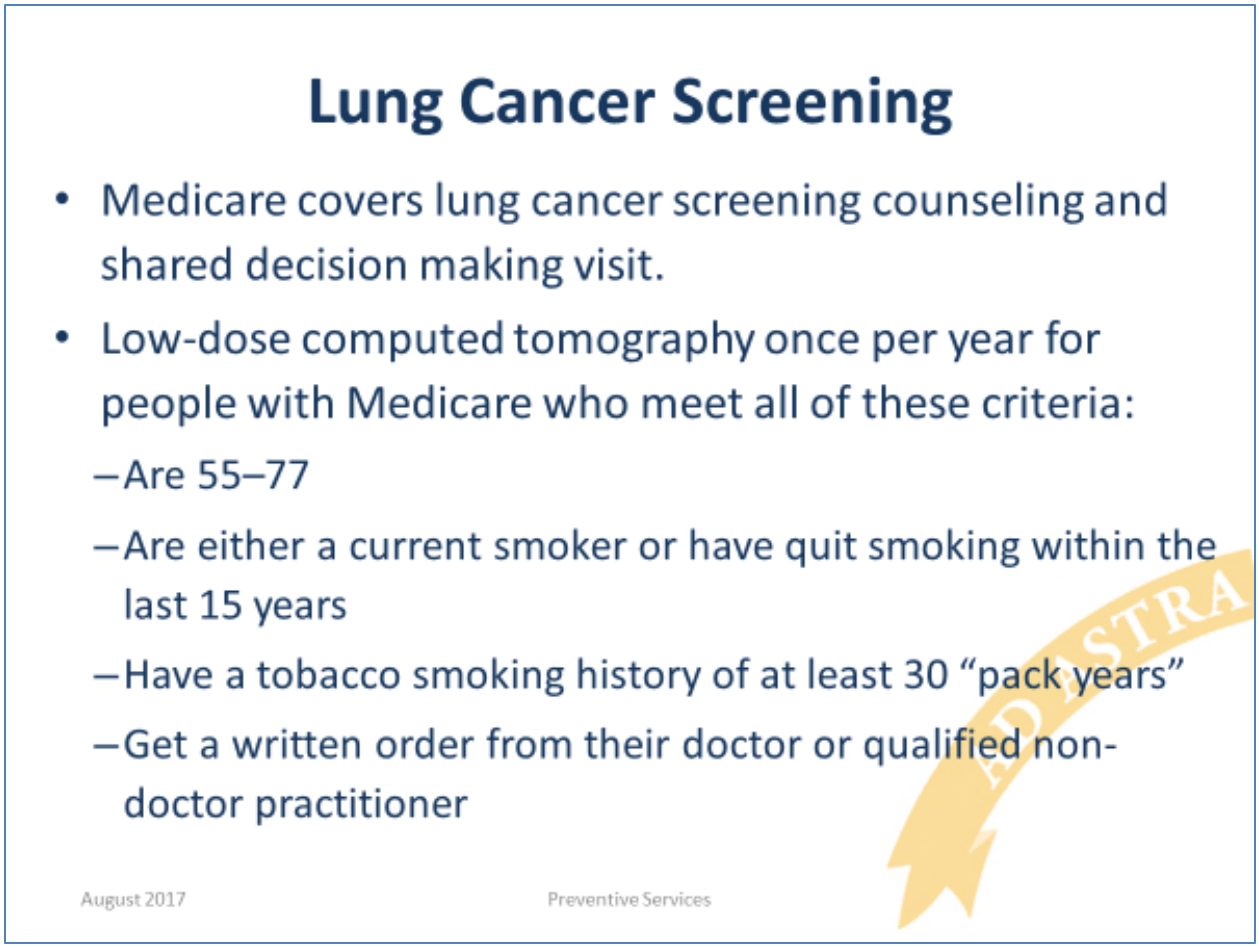
Except for pregnant women, Medicare covers one annual voluntary HIV screening for people with Medicare between the age of 15 and 65, without regard to perceived risk. Except for pregnant people with Medicare, Medicare will also cover one annual, voluntary screening for people who are younger than 15 or older than 65, who are at increased risk for the infection.

The following people are considered at increased risk for HIV infection:

- Men who have sex with men
- Men and women having unprotected sex
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons who have acquired or request testing for other sexually-transmitted infectious diseases
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request the HIV test despite reporting no individual risk factors
- Persons with new sexual partners
- Persons whose individualized medical history, as properly assessed and documented by an appropriate health care professional, indicates an increased risk for the disease

For people with Medicare who are pregnant, up to 3 voluntary screenings during a pregnancy are covered.

There's no cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.



- Medicare covers lung cancer screening with low-dose computed tomography (x-ray machine scans the body and uses low doses of radiation to make detailed pictures of the lungs) once per year for people with Medicare who meet all of these criteria:
    - Are 55-77,
    - Are either a current smoker or have quit smoking within the last 15 years,
    - Have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years), and
    - Get a written order from their doctor or qualified non-doctor practitioner
- Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

You pay nothing for this service if the primary care doctor or other qualified primary care practitioner accepts assignment.

Resource: cdc.gov/cancer/lung/basic_info/screening.htm

Medicare Part B covers medical nutrition therapy (MNT) services and certain related services. A registered dietician or nutrition professional who meets certain requirements can provide these services, which may include an initial nutrition and lifestyle assessment, one-on-one nutritional counseling, and follow-up visits to check on your progress in managing your diet.

If you're in a rural area, a registered dietician or other nutritional professional in a different location may be able to provide MNT to you through telehealth.

If you get dialysis in a dialysis facility, Medicare covers MNT as part of your overall dialysis care.

People with Part B who meet at least one of these conditions are eligible:

- Have diabetes
- Have kidney disease
- Have had a kidney transplant in the last 36 months

People with Part B must get a referral from their doctor or qualified non-doctor practitioner for the service. You pay nothing for these services if the doctor or other health care professional accepts assignment.

Clinical evidence indicates that intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m2, is reasonable and necessary for the prevention or early detection of illness or disability. It's appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Medicare may cover up to 22 face-to-face intensive counseling sessions over a 12-month period.

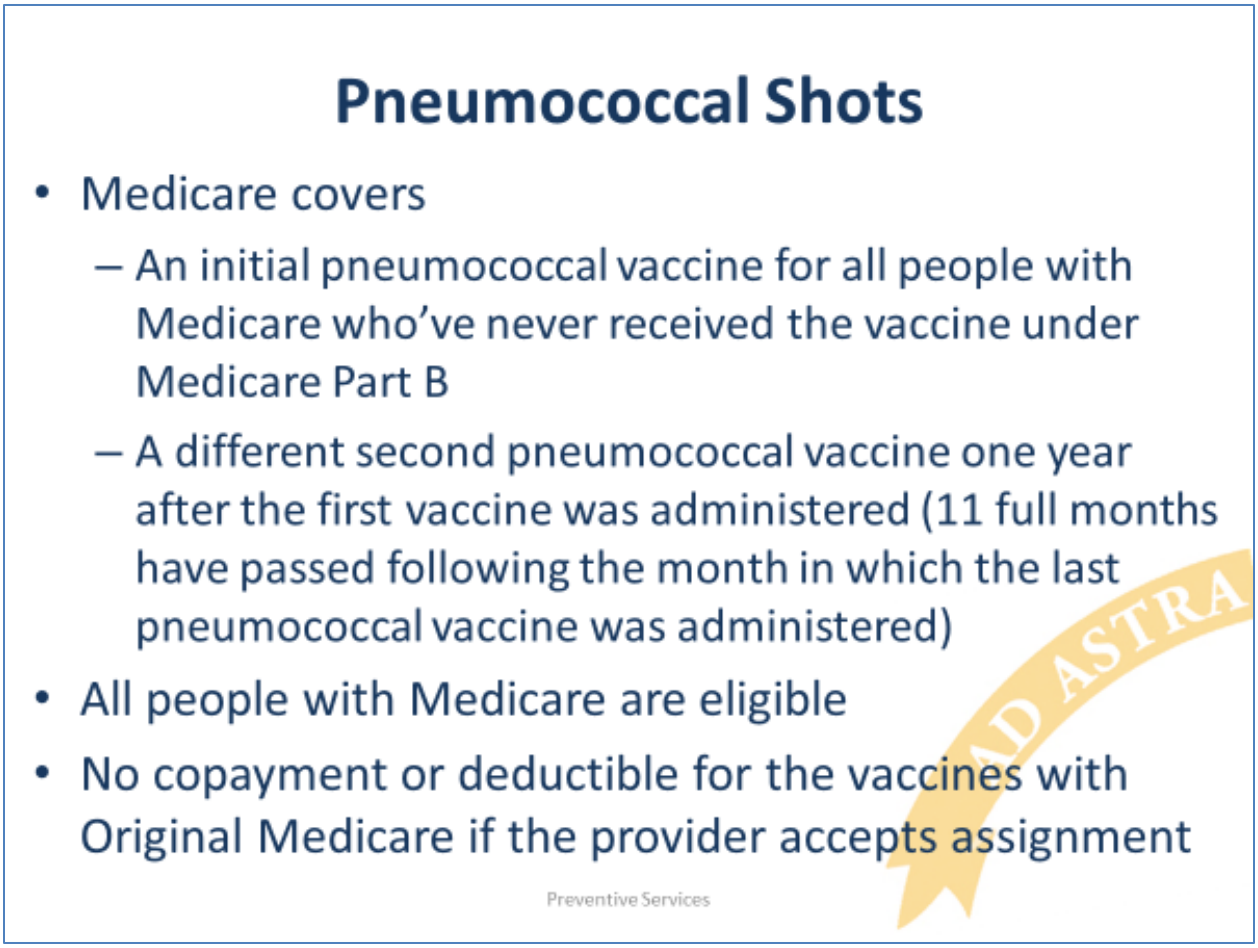
Intensive behavioral therapy for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m2)
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions of diet and exercise

For people with Medicare with obesity, who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting, Medicare covers one face-to-face visit every:

- Week for the first month
- Other week for months 2–6
- Month for months 7–12, if the beneficiary meets the 3 kg (6.6 lbs.) weight loss requirement as discussed below

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, people must have achieved a reduction in weight of at least 3 kg (6.6 lbs.) over the course of the first 6 months of intensive therapy. This determination must be documented in the doctor's office records, consistent with usual practice. For those who don't achieve a weight loss of at least 3kg during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.



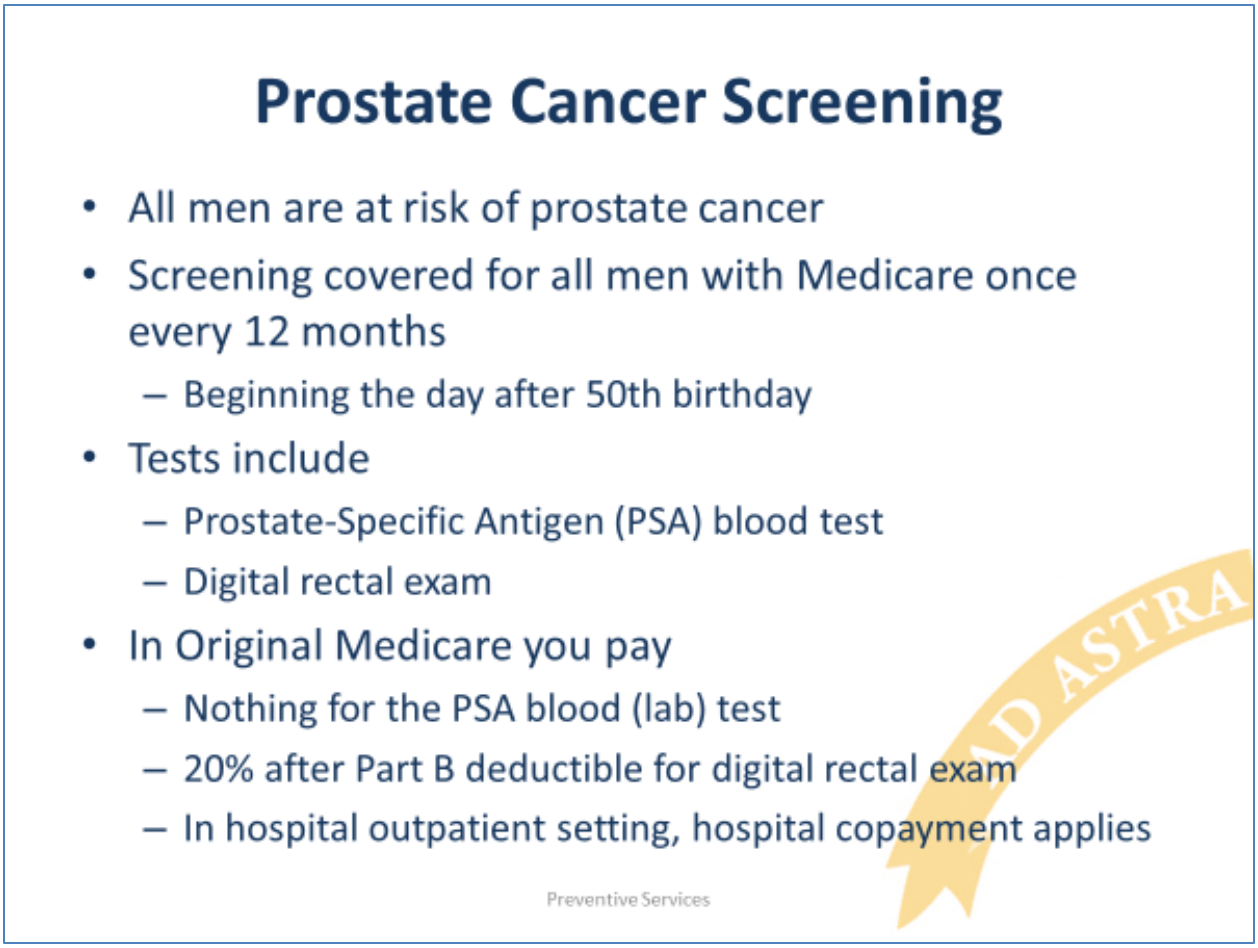
Medicare covers the following:

- An initial pneumococcal vaccine for all people Medicare who've never received the vaccine under Medicare Part B
- A different second pneumococcal vaccine one year after the first vaccine was administered (11 full months have passed following the month in which the last pneumococcal vaccine was administered)

Since the updated Advisory Committee on Immunization Practices recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a person with Medicare who's 65 or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the 2 recommended pneumococcal vaccinations. Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare doesn't require that a doctor of medicine or osteopathy order the vaccines; therefore, people with Medicare may receive the vaccine upon request without a doctor's order and without doctor supervision.

Medicare Part B covers these vaccines. You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.

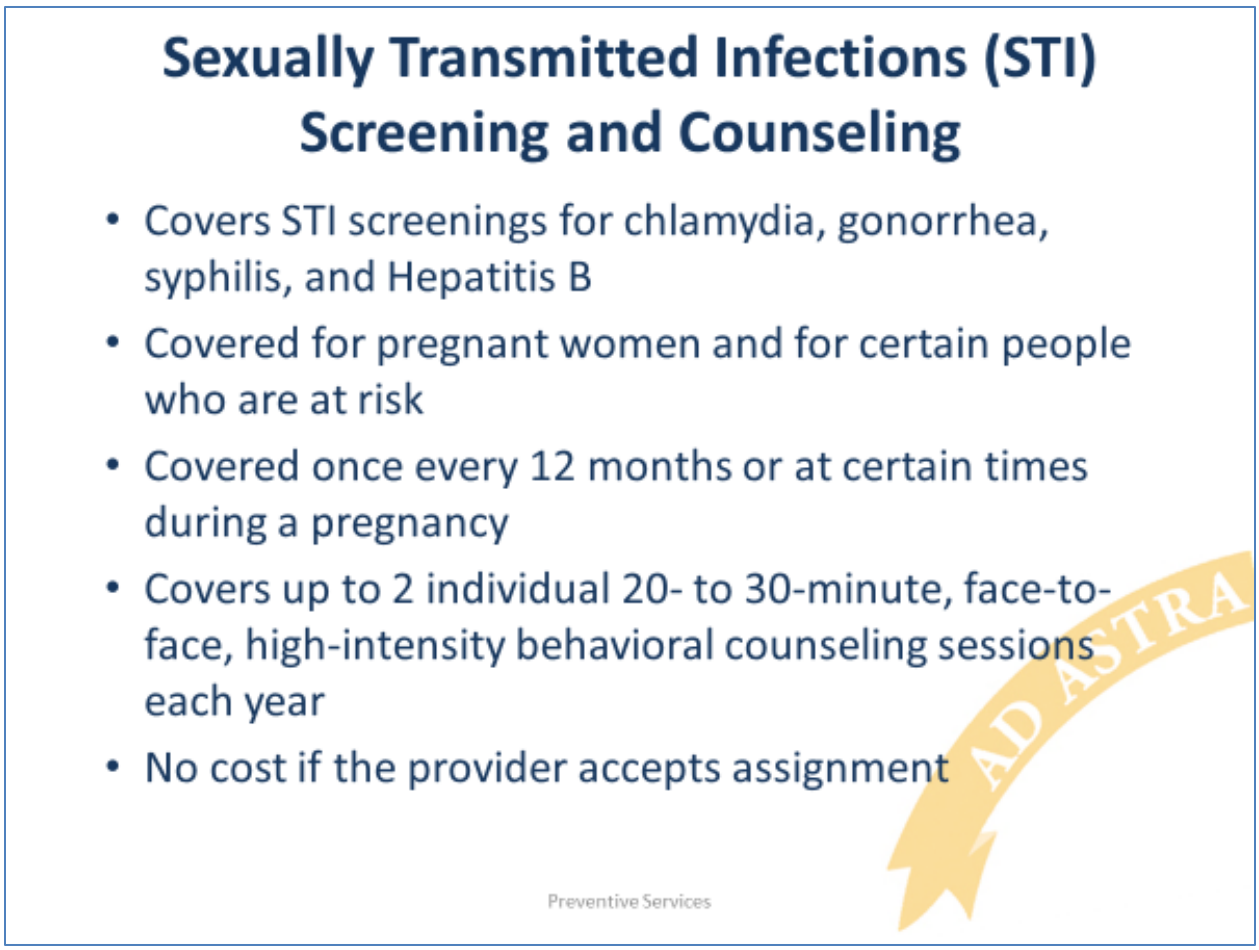


All men are at risk for prostate cancer. However, the causes of prostate cancer aren't yet clearly understood. Through research, several factors have been identified that increase your risk, including the following:

- Family history of prostate cancer
- Men 50 and older
- Diet of red meat and high fat dairy
- Smoking

Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer once every 12 months for all men with Medicare 50 and older (coverage begins the day after their 50th birthday). The 2 most common screenings used by doctors to detect prostate cancer are the screening prostate-specific antigen (PSA) blood test and the screening digital rectal examination.

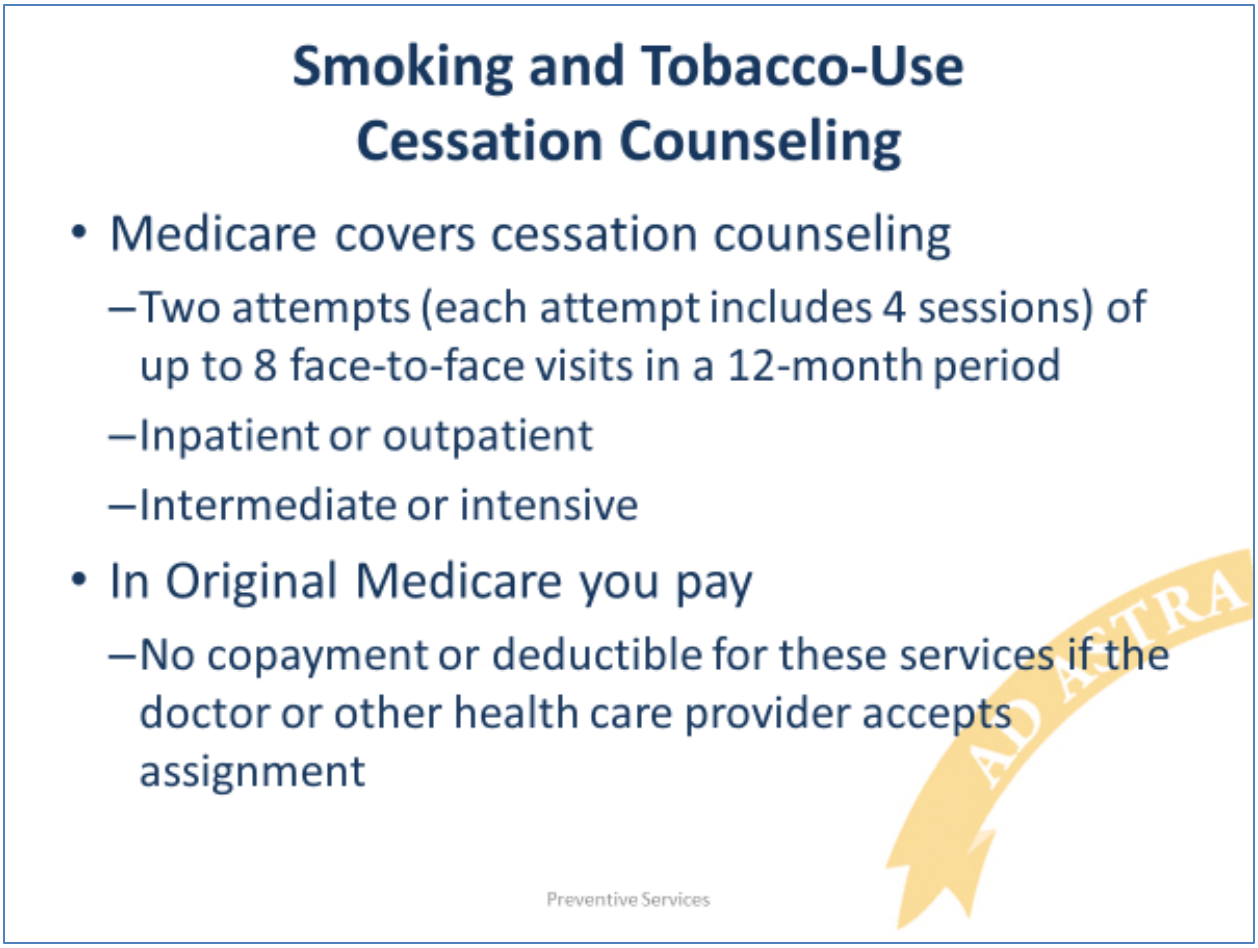
The screening PSA test must be ordered by a doctor. You pay nothing for the screening PSA blood test (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit) although a copayment may apply in a hospital outpatient setting. The Medicare Part B deductible and copayment apply to the digital rectal exam.



Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for people with Medicare who are pregnant, and for certain people who are at increased risk for an STI, when the tests are ordered by a primary care doctor or other primary care practitioner. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare covers up to 2 individual 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other practitioner, and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

You pay nothing for these services if the primary care doctor or other qualified primary care practitioner accepts assignment.



Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Medicare covers counseling to prevent tobacco use for outpatient and hospitalized people with Medicare

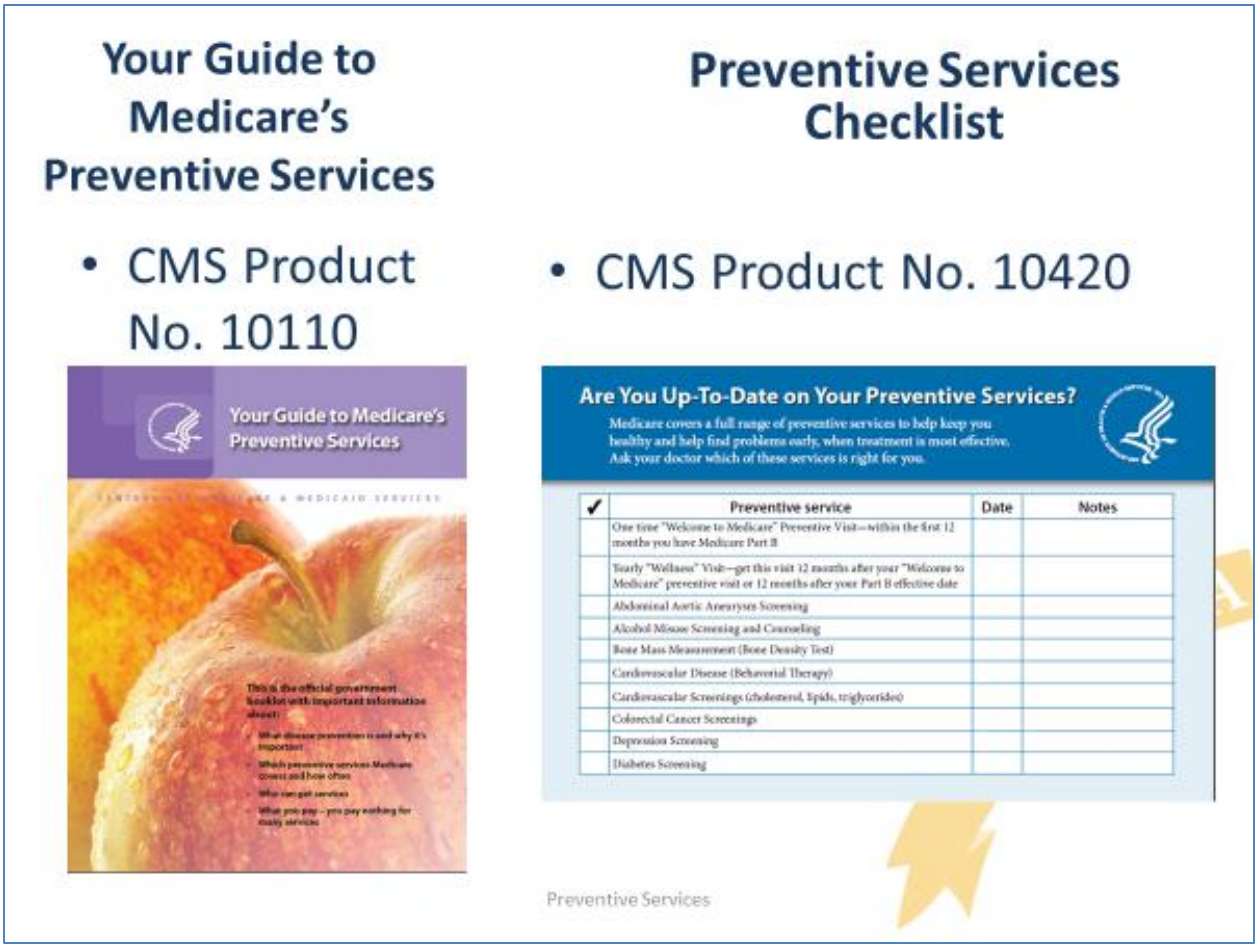
- Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease
- Who are competent and alert at the time that counseling is provided
- Whose counseling is furnished by a qualified doctor or other Medicare-recognized practitioner

Medicare will cover 2 cessation attempts per year. Each attempt may include up to 4 counseling sessions, with the total annual benefit covering up to 8 sessions in a 12-month period.

Tobacco cessation counseling services can be provided in the hospital, or on an outpatient basis. However, tobacco cessation counseling services aren't covered if the primary reason for the hospital stay is tobacco cessation. You must get counseling from a qualified Medicare provider (doctor, doctor's assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).

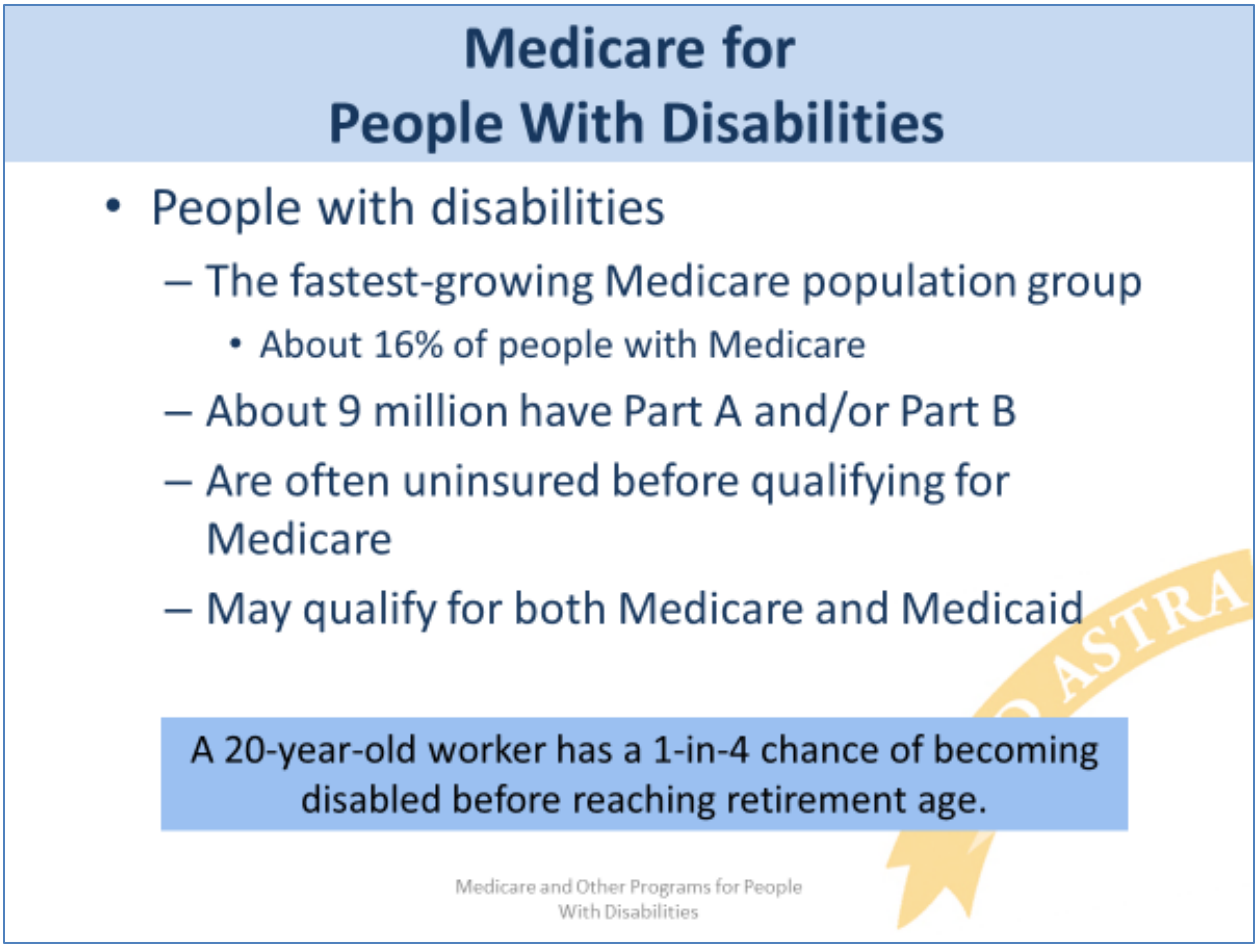
Both the copayment and deductible are waived if the counseling sessions are furnished by a doctor or other health care provider who accepts assignment. A copayment may apply in a hospital outpatient setting.

Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a doctor.



"Your Guide to Medicare's Preventive Services" is a publication written in plain language so that people with Medicare can better understand the preventive benefits that are covered, the criteria for who is covered, the frequency of coverage, and the costs associated with these services. This publication is available at Medicare.gov/Pubs/pdf/10110.pdf.

A helpful checklist is available for people with Medicare. It lists Medicare-covered preventive services and can help them keep track of when they receive those services for which they qualify. This can be found at Medicare.gov/Pubs/pdf/11420.pdf.



People with disabilities:

- Represent the fastest-growing group of the Medicare-eligible population
- Make up about 16% of people with Medicare (2015)
- Approximately 9 million have Part A or Part A and Part B (2015)
- Are often uninsured before they qualify for Medicare
- May qualify for both Medicare and Medicaid

Social Security studies show that a 20-year-old worker has a 1-in-4 chance of becoming disabled before reaching retirement age.

For more information, visit kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/ and ssa.gov/disabilityfacts/facts.html.

To qualify for Medicare based on a disability, an individual must meet the Social Security (SSA) definition of having a disability. SSA defines a disability as the inability to do substantial work because of a medical impairment, which is expected to last at least a year or to result in death.

This is a strict definition of disability. SSA program rules assume that working families have access to other resources to provide support during periods of short-term disabilities, including workers' compensation, insurance, savings, and investments. For more information, visit socialsecurity.gov/disabilityfacts/.

There are two federal programs that provide cash benefits to certain people with disabilities. These programs, administered by Social Security (SSA), include

- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI) Disability

SSA pays benefits to people who meet the strict definition of disability. Unlike some other programs, SSA doesn't give monthly cash benefits to people with partial disability or short-term disability.

Certain family members of disabled workers can also get monthly cash benefits from SSA.

Social Security Disability Insurance pays monthly cash benefits to you and certain members of your family if you're insured—meaning you worked long enough, recently enough, and paid Social Security (SSA) taxes.

Generally, you need 40 credits, 20 of which were earned in the last 10 years ending with the year you become disabled. However, younger workers may qualify with fewer credits.

The monthly cash benefit you're eligible for is based on your average lifetime earnings.

Generally, your disability benefits will continue as long as your medical condition hasn't improved and you can't work. Benefits won't necessarily continue indefinitely. Because of advances in medical science and rehabilitation techniques, many people with disabilities recover from serious accidents and illnesses. If you get benefits, SSA will review your medical condition from time to time to make sure you continue to have a qualifying disability.

The people who can get Social Security Disability Insurance include:

The worker, if he or she paid enough into Social Security (SSA) to qualify

A spouse

- At 62 or older
- At any age if caring for a child who's under 16 or disabled
- At 50 if the person applying is a disabled widow(er)

If something happens to a worker, benefits may be payable to their widow, widower or surviving divorced spouse with a disability if the following conditions are met:

- He or she is between ages 50 and 60,
- Their condition meets the definition of disability for adults, and
- The disability started before or within seven years of the worker's death

Divorced spouses may qualify if

- Married to the worker for at least 10 years
- Unmarried
- Not entitled to a higher Social Security benefit on his or her own record

A child

- A child under 18 may be disabled, but SSA doesn't need to consider the child's disability when deciding if he or she qualifies for benefits as a person's dependent. The child's benefits normally stop at 18, unless he or she is a full-time student (benefits can continue until 19), or is disabled
- Not married and disabled before 22

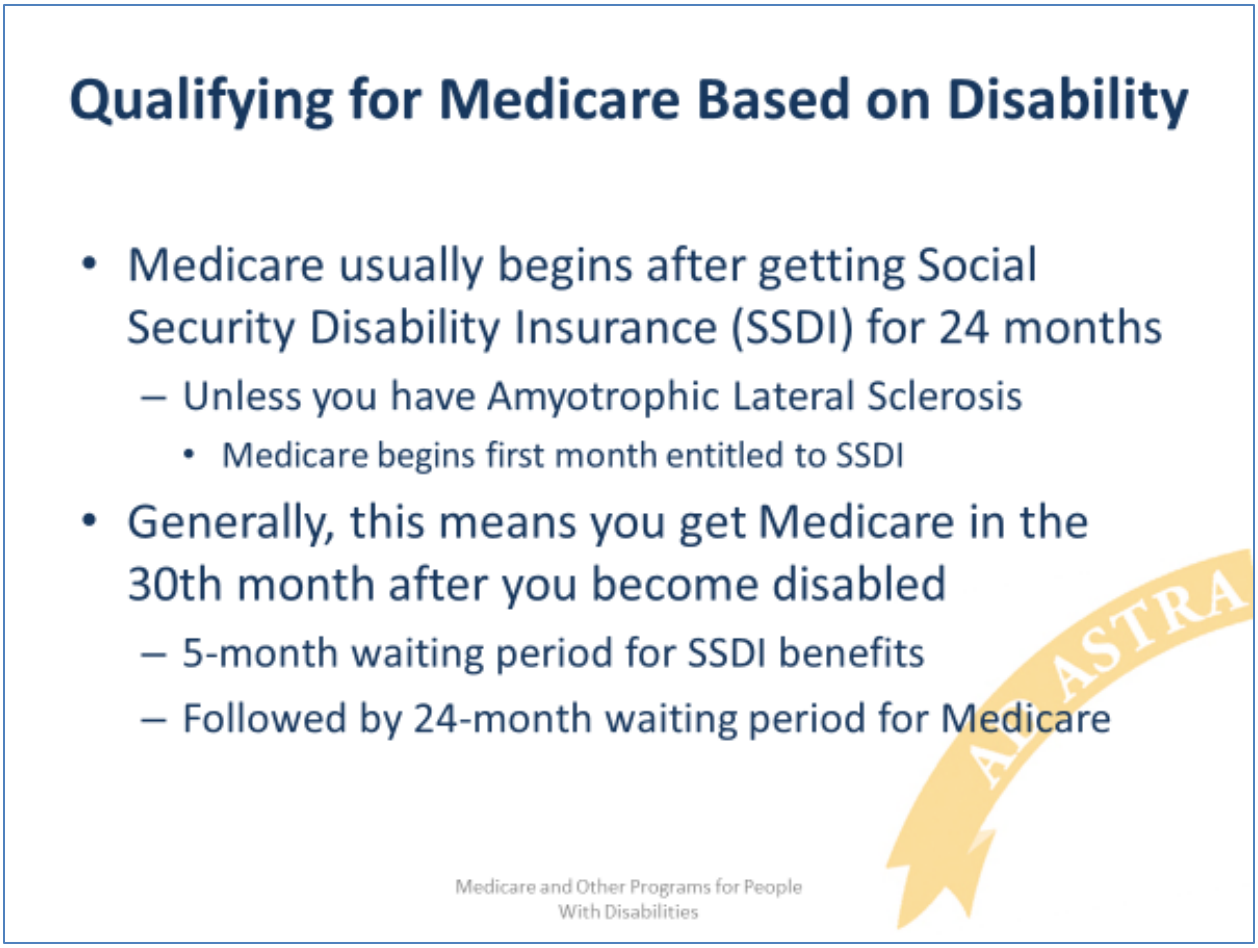
In most cases, there's a waiting period of 5 full calendar months from the time your disability began, until your Social Security Disability Insurance benefits can begin. Once your application is approved, you'll get your first Social Security benefit starting on the 6th full month after the date your disability began.

- If SSA decides your disability began on January 15, your first disability benefit would be paid for the month of July.
- Social Security benefits are paid during the month after the month in which they're due, so you'd get your July benefit check in August.

The 5-month waiting period for cash benefits doesn't apply to people who get childhood disability benefits, or to some people who were previously entitled to disability benefits (in the past 5 years).

Generally, to be eligible for Supplemental Security Income, you must

- Be 65 or older, blind, or disabled
- Have limited income and resources—less than $2,000 in resources for an individual and less than $3,000 for a married couple
- Be a U.S. citizen or national, or a qualified alien (lawfully present non-citizen who was lawfully residing in the United States on August 22, 1996)
- Reside in 1 of the 50 states, the District of Columbia, or the Northern Mariana Islands

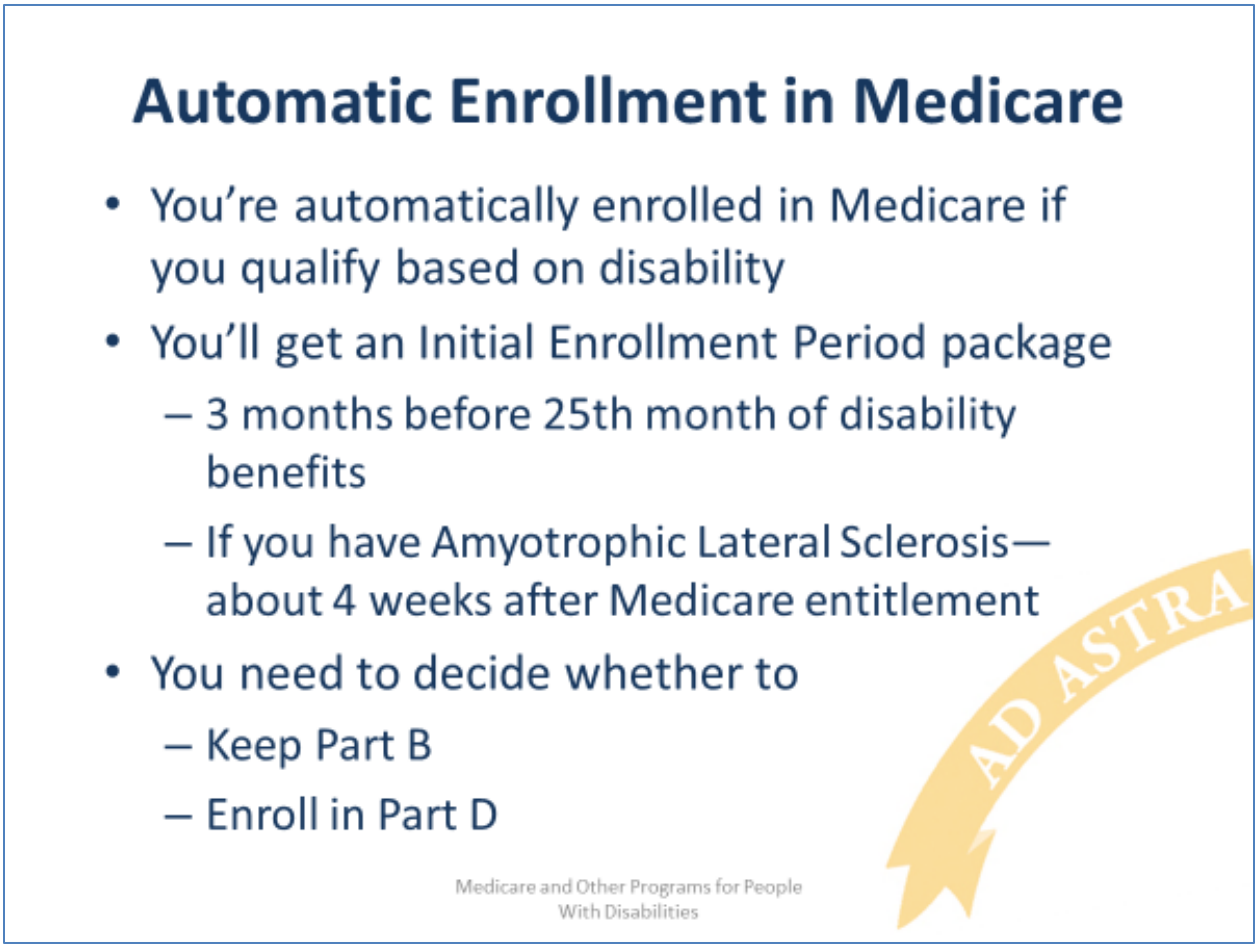


Medicare also covers 2 groups of individuals under 65:

- People under 65 with a disability who have been entitled to Social Security (SSA) benefits for 24 months.
- People with End-Stage Renal Disease (ESRD) who have earned at least 6 work credits (or are the dependent child or spouse of someone who has earned 6 work credits) in a period of 13 calendar quarters ending with the quarter of ESRD onset. People with ESRD don't need to be entitled to Social Security benefits to qualify for Medicare. However, if they're also entitled to disability benefits, they may qualify under both programs.

In most cases, you must be entitled to disability benefits for 24 months before Medicare can begin. Since there is a 5-month waiting period for Social Security Disability Insurance, the earliest that Medicare can start is usually the 30th month after you become disabled. However, there are 2 exceptions:

- The 5-month waiting period for cash benefits doesn't apply to people who get childhood disability benefits, or to some people who were previously entitled to disability benefits (in the past 5 years).
- The 24-month Medicare waiting period doesn't apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, known as Lou Gehrig's Disease). People with ALS get Medicare the first month they're entitled to disability benefits.



You'll automatically get Part A and Part B 24 months after you get disability benefits from Social Security (SSA), or certain disability benefits from the Railroad Retirement Board. If you have Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease), you'll automatically get Part A and Part B the month your disability benefits begin.

You'll get your red, white, and blue Medicare card in the mail 3 months before your 25th month of disability. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B and will pay Part B premiums. If you don't keep Part B and decide to enroll later, you'll likely pay a late enrollment penalty. Call SSA at
1-800-772-1213 if your card doesn't arrive.

Having employer or union coverage while you or your spouse (or family member, if you're disabled) is still working can affect your Part B enrollment. You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment. In certain situations, when you're enrolled in Part A, you must also be enrolled in Part B, like if

- You want to buy a Medicare Supplement Insurance (Medigap) policy
- You want to join a Medicare Advantage Plan
- You're eligible for TRICARE
- Your employer coverage requires you or your spouse or family member to have it (talk to your employer's or union's benefits administrator)

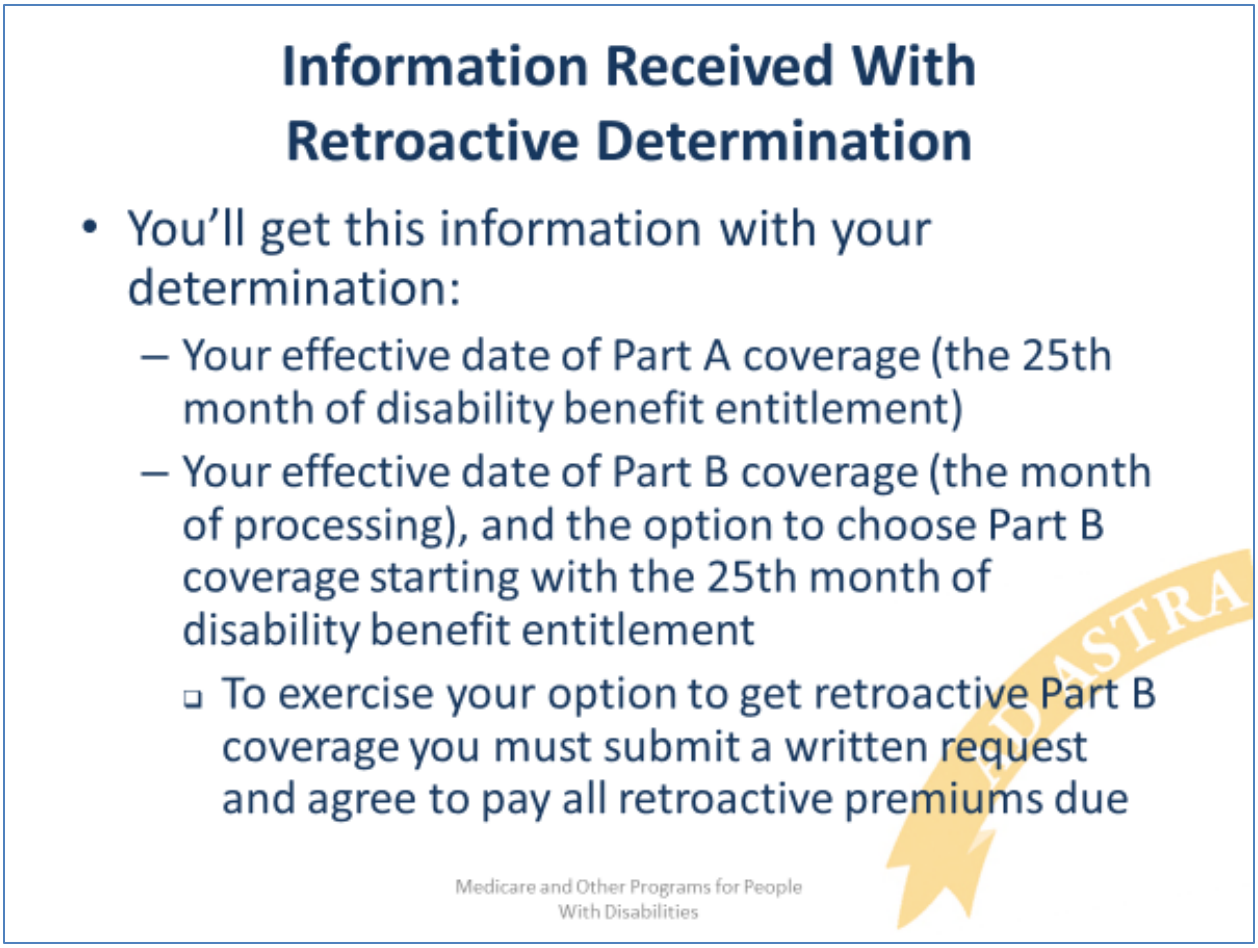
Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan (Part D). If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage, or you don't get Extra Help, you'll likely pay a late enrollment penalty if you join a plan later.

In some cases, a disability determination may be made based on an appeal, giving you an earlier date of entitlement to disability benefits. In other cases, if your application isn't processed in a timely manner, you may be entitled to retroactive Medicare Part A coverage.

In some cases, your entitlement to Medicare may be retroactive:

- If your disability benefits are retroactive
- Your Medicare card will show effective date

If you got Medicare-covered services before you got your Medicare card, you may request that your provider submit those claims to Medicare. The date of service can't be before the effective date on your Medicare card.



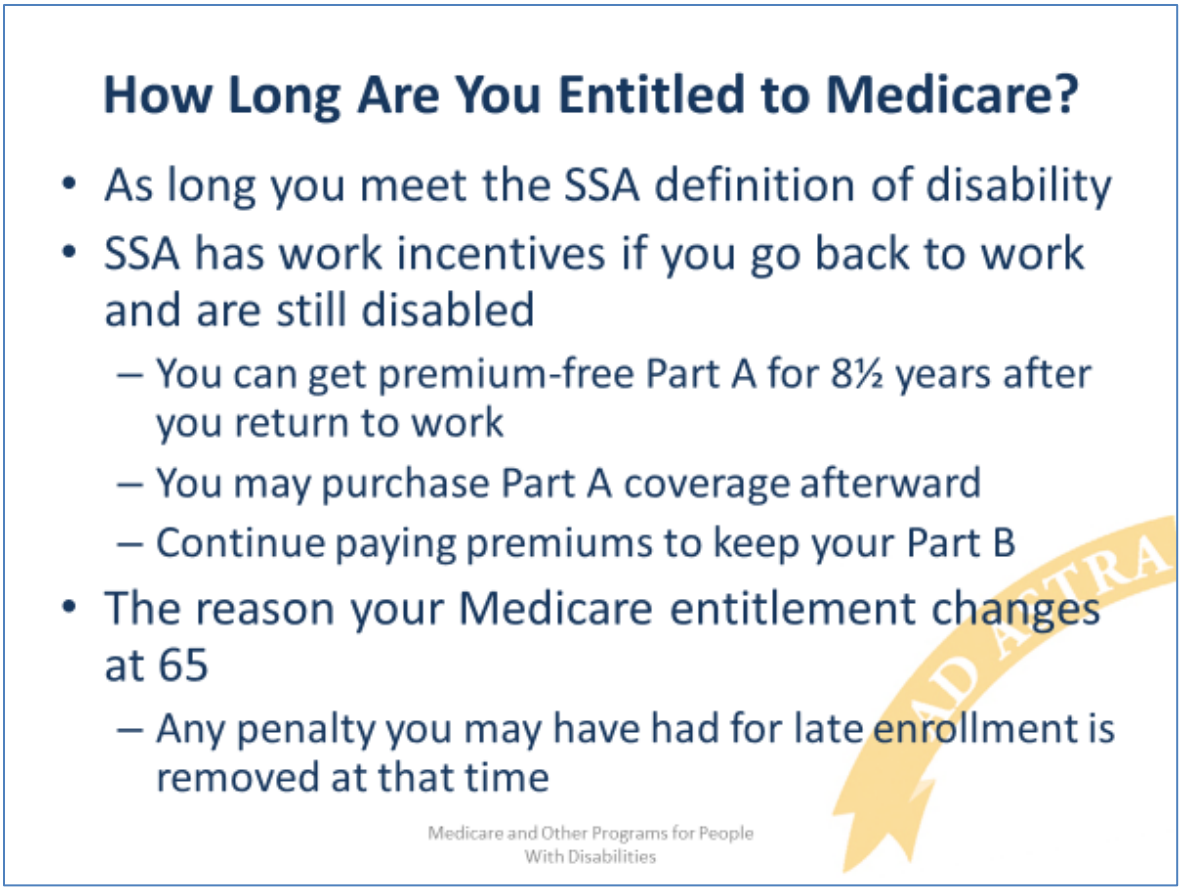
You'll get this information with your determination:

- Your effective date of Part A coverage (the 25th month of disability benefit entitlement)
- Your effective date of Part B coverage (the month of processing), and the option to elect Part B coverage starting with the 25th month of disability benefit entitlement

To exercise your option to get retroactive Part B coverage, you must submit a written request and agree to pay all retroactive premiums due. If you choose retroactive Part B coverage, you'll get a second letter stating that you have retroactive Part B coverage. The letter also gives instructions for the provider to file Part B claims outside the timely filing limit.

Regardless of the situation, your Part A start date will always be the 25th month after your disability benefit is approved. Your Part B start date will be the 25th month after your disability benefit is approved, if, at the time the disability application is processed, you owe less than 6 months of previous Part B premiums. If you owe 6 or more months of premiums, Part B becomes effective the month your disability application is processed.

NOTE: Because there's uncertainty in determining the Initial Enrollment Period (IEP) for an individual filing for re-entitlement to disability benefits, the Part B enrollment request is deemed to have been filed in the 3rd month of the IEP. This ensures that you have the opportunity for coverage at the earliest possible date.



You're entitled to Medicare as long as you continue to meet the requirements for Social Security disability benefits. If Social Security (SSA) determines that your disability benefits should be stopped because your condition has improved and you're no longer considered disabled, your Medicare will end the same month your disability benefits end.

SSA has work incentives to support people who are still medically disabled but try to work. Continuation of Medicare coverage is a type of incentive.

- You may have at least 8½ years of extended Medicare coverage if you return to work. Medicare continues even if SSA determines you can no longer get cash benefits because you earn too much.
- If, after you've exhausted your 8½ years of extended Medicare coverage, you continue to work and continue to have a disability, you may buy Part A, or Part A and Part B for as long as you continue to be disabled. This is called "Medicare for the Working Disabled." In some cases, your state may help you pay your Part A premiums. See slide 45 for more information.
- If you were paying an increased Part B premium during the time you were getting premium-free Part A, but now are eligible for Part B because you're enrolling in Part A for the working disabled, your Part B penalty can be removed.

If you're getting Medicare based on disability when you reach 65, you'll have continuous coverage with no interruption. You'll get Part A for free, even if you've been buying it. However, the reason for your Medicare entitlement changes from disability to age. If you didn't have Part B when you were disabled, you'll automatically be enrolled in Part B when you turn 65, and will again be able to decide whether or not to keep it. If you don't enroll in Part B when first eligible, and you don't qualify for a Special Enrollment Period (SEP), you may have to pay a late enrollment penalty for as long as you have Part B. Your Part B premium may be increased 10% for every full 12 month period in which you could've been enrolled in Part B but weren't. If you were paying a Part B late enrollment penalty while you were disabled, the penalty will be removed when you reach 65.

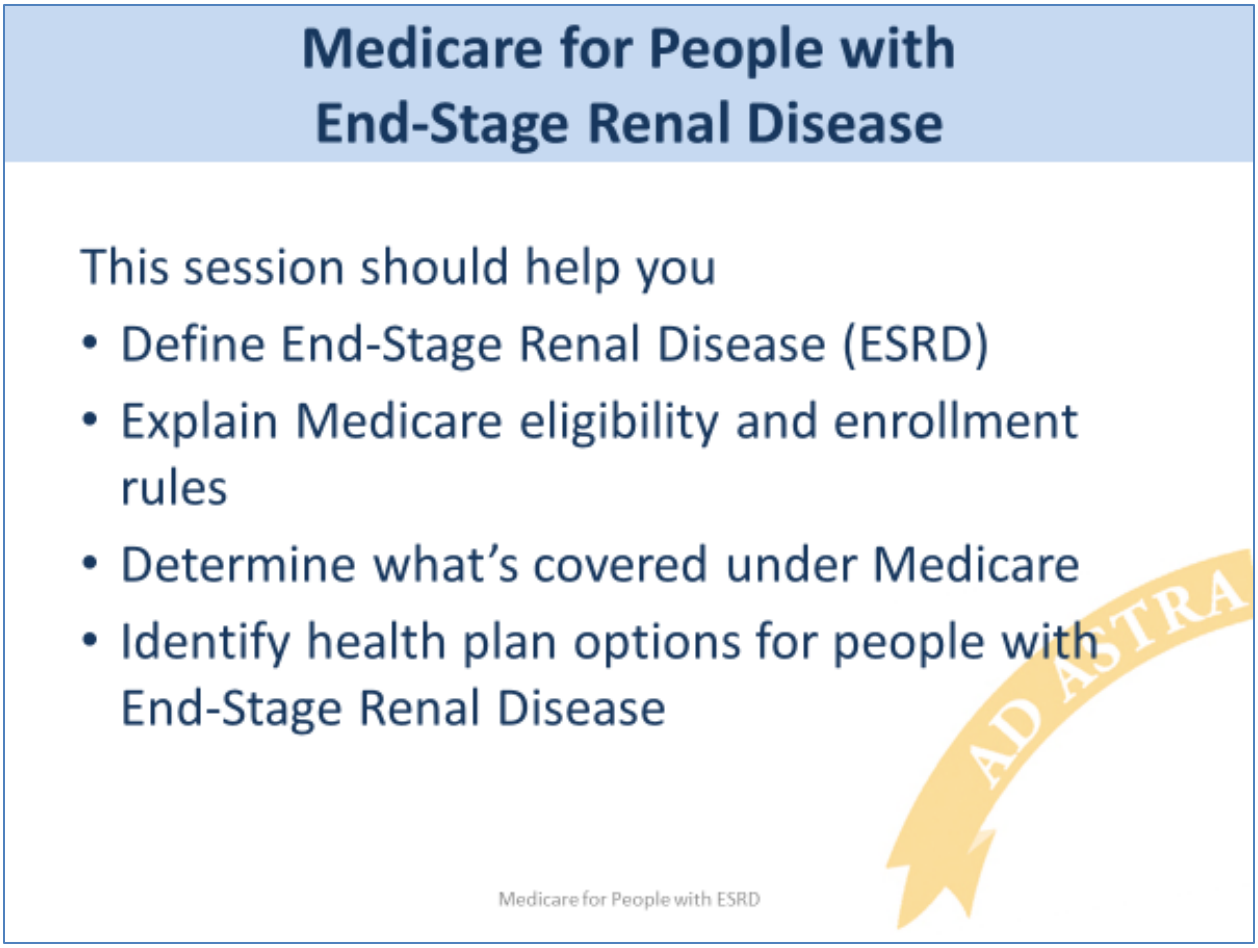
Even if you don't have a disability, you probably plan to get Social Security benefits someday. You'll want a my Social Security account to

- Request a replacement Social Security card (if you meet certain requirements)
- Check the status of your application or appeal
- Keep track of your earnings (verify them every year)
- Get an estimate of your future benefits if you're still working
- Get a letter with proof of your benefits if you currently get them
- Manage your benefits

Change your address and phone number
Start or change your direct deposit

- Get a replacement Medicare card
- Get replacement SSA-1099 (Social Security income) or SSA-1042S (Social Security income for non-citizens) tax forms. These forms are not available for people who get Supplemental Security Income (SSI).

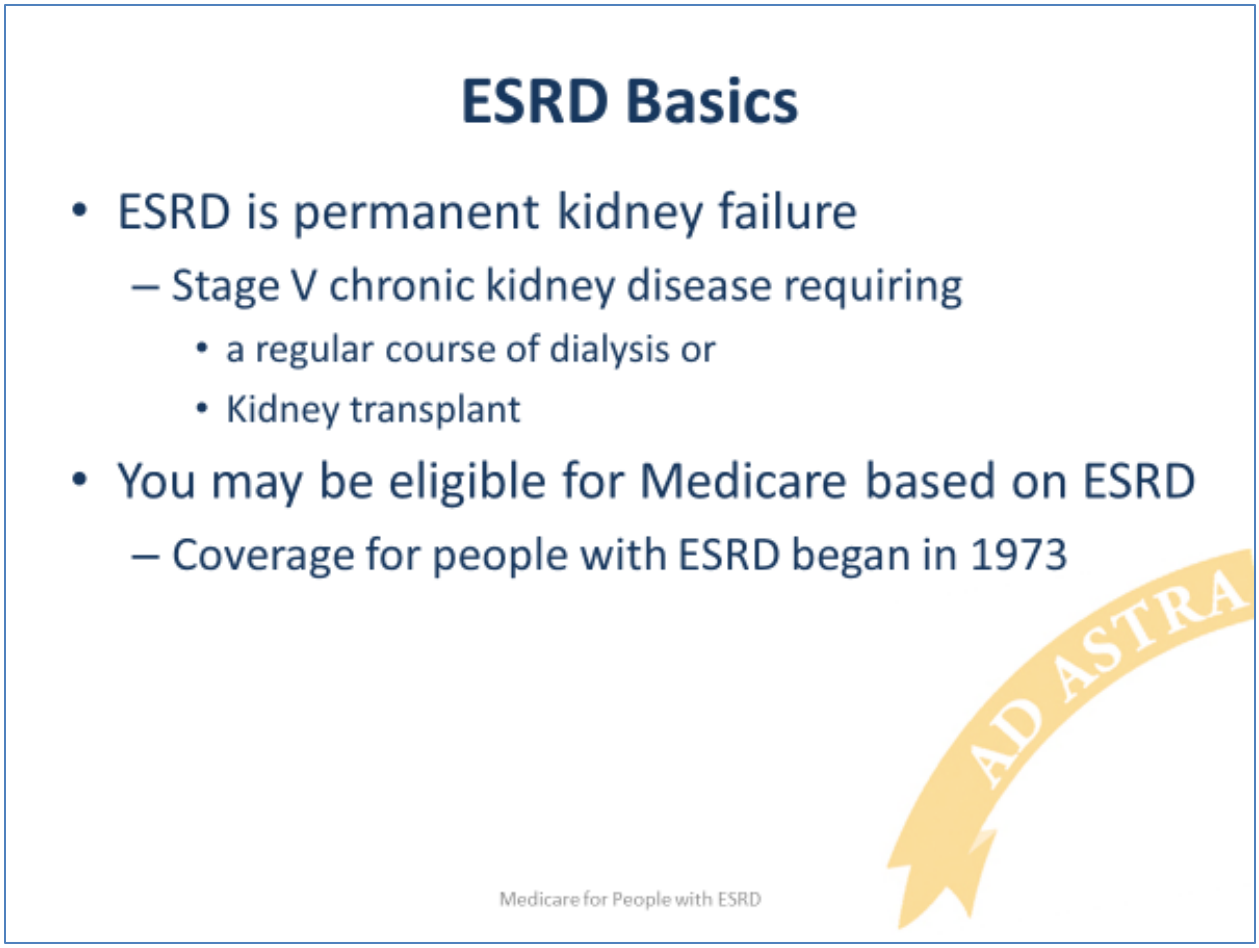
In addition, Social Security (SSA) also has a factsheet to help you or others create an account at ssa.gov/pubs/EN-05-10540.pdf.



This session should help you

- Define End-Stage Renal Disease (ESRD)
- Explain Medicare eligibility and enrollment rules
- Determine what's covered under Medicare
- Identify health plan options for people with ESRD

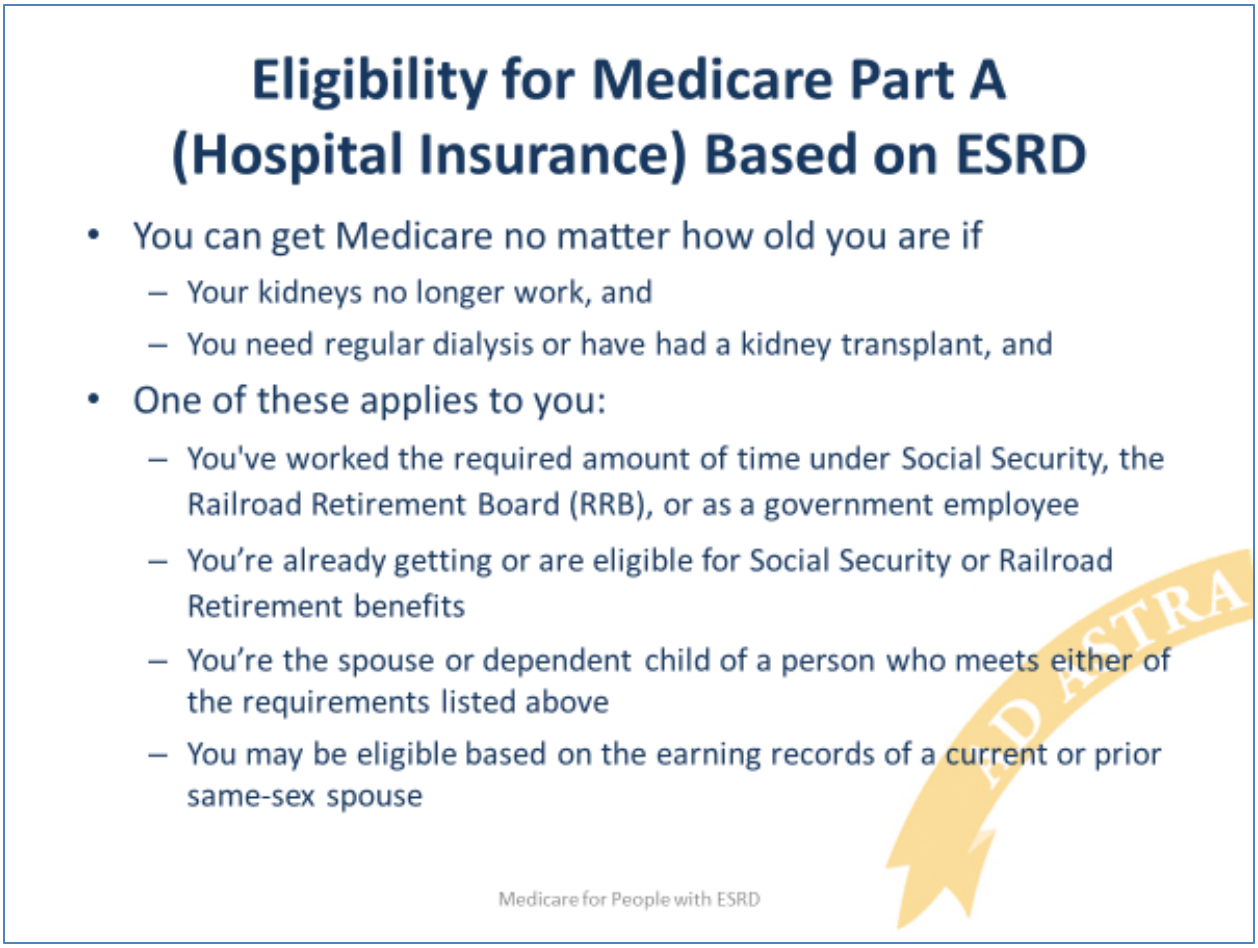
NOTE: From this point on we will use the acronym ESRD when discussing End-Stage Renal Disease.



ESRD is defined as permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

There are 5 stages of chronic kidney disease (CKD). The National Kidney Foundation developed guidelines to help identify the levels of kidney disease. If you have Stage 5 CKD, you may be eligible for Medicare based on ESRD. Visit kidney.org for more information about CKD.

In 1972, Medicare was expanded to include 2 new groups of people: certain people with a disability, and those with ESRD. The expanded coverage began in 1973.



You can get Medicare no matter how old you are if your kidneys no longer work, you need regular dialysis, or have had a kidney transplant, and one of these applies to you:

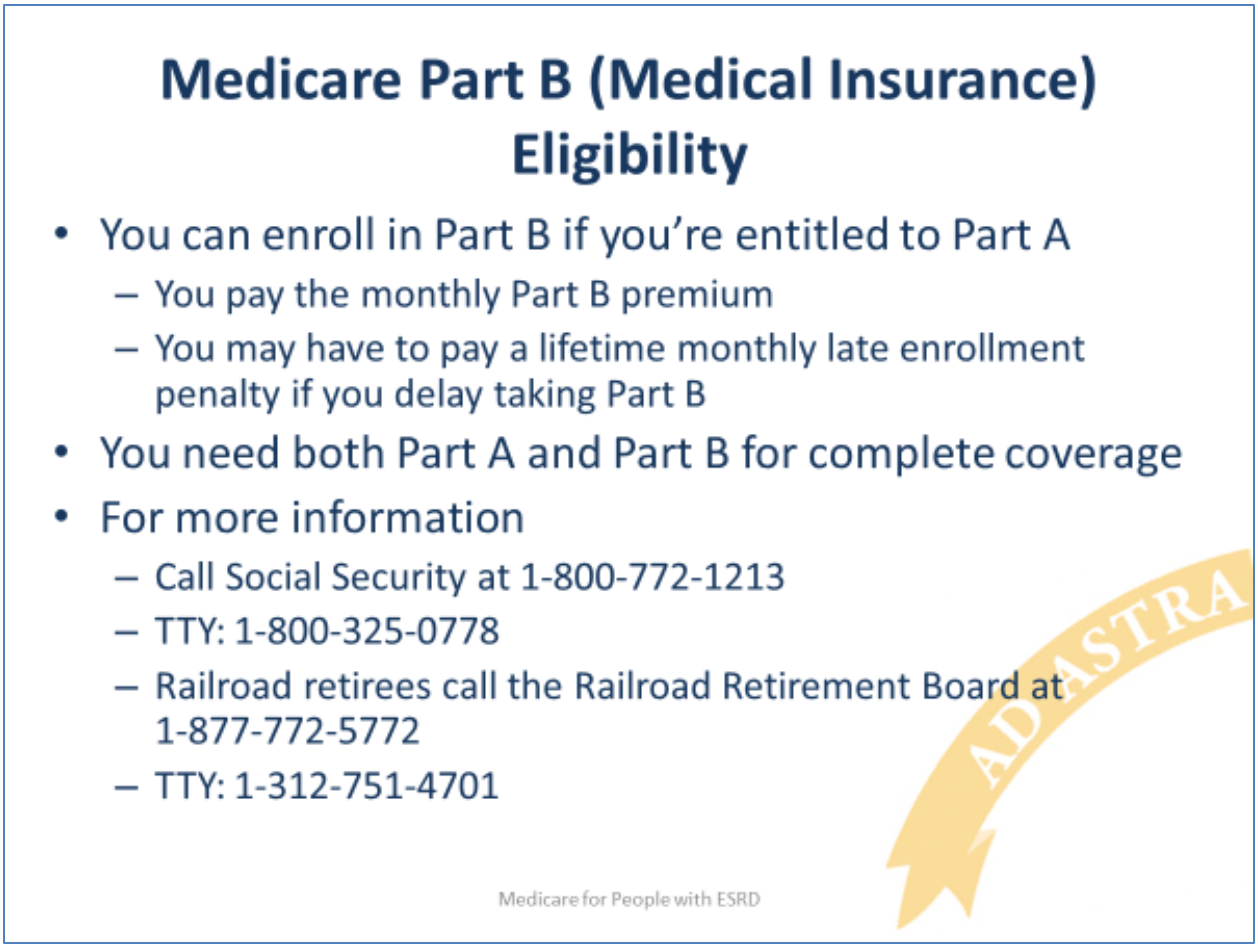
- You've worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee
- You're already getting or are eligible for Social Security or Railroad Retirement benefits
- You're the spouse or dependent child of a person who meets either of the requirements listed above

You may be eligible based on the earning records of a current or prior same-sex spouse if you

- Were married in a state that permits same-sex marriage
- Were living together at the time of the application, or while the claim was pending final determination in a state that recognizes same-sex marriage, and
- Were married for at least 10 years (if divorced)

You must also file an application, and meet any deadlines or waiting periods that apply.

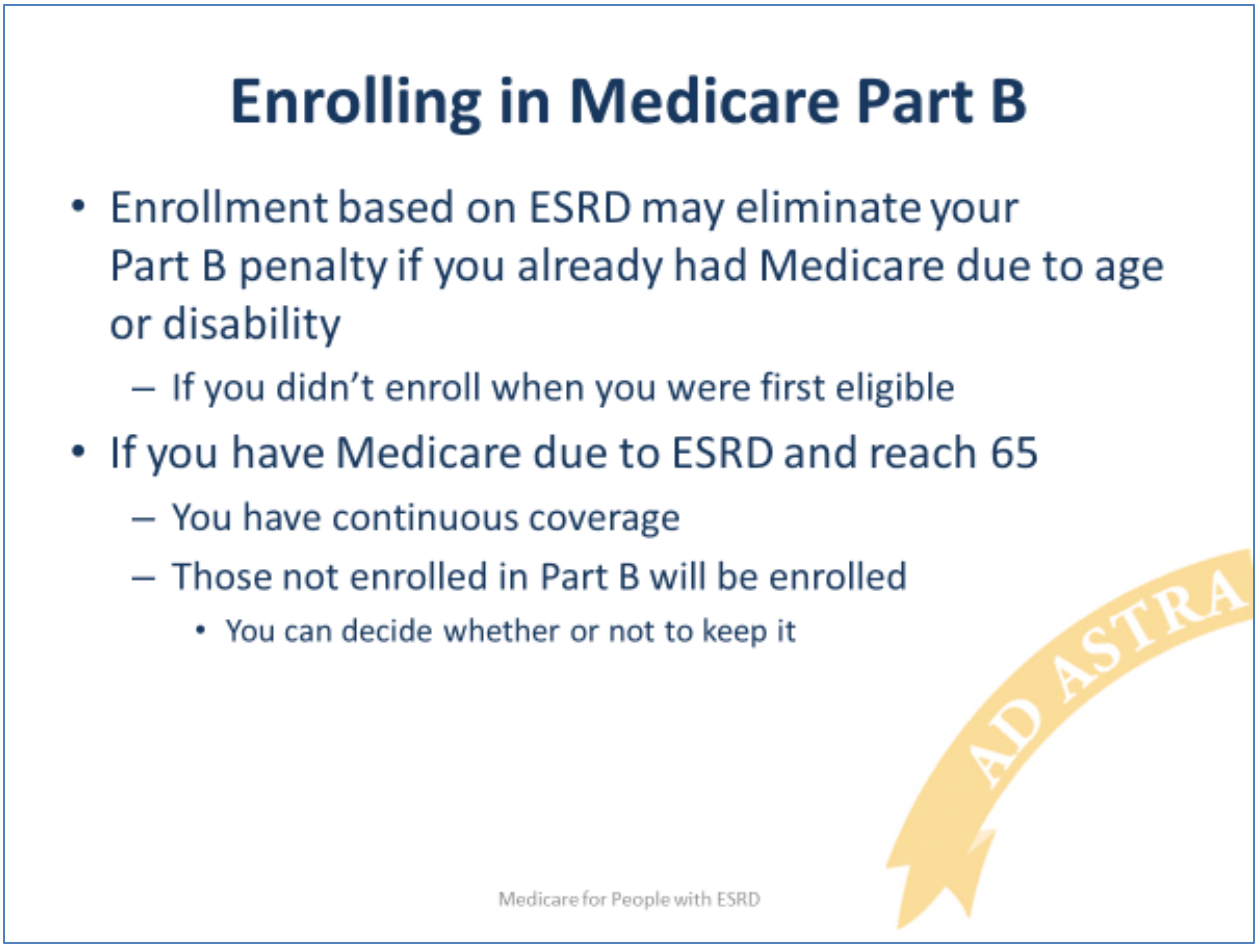
NOTE: See CMS Product No. 11392 "Medicare for Children With End-Stage Renal Disease," at Medicare.gov/Pubs/pdf/11392.pdf for more information regarding children with ESRD.



If you qualify for Medicare Part A, you can also get Medicare Part B (Medical Insurance). Enrolling in Part B is your choice and isn't automatic. If you don't enroll in Part B when you get Part A, you must wait until a General Enrollment Period (January 1–March 31 each year) to apply, and you may have to pay a lifetime monthly late enrollment penalty. You'll need both Part A and Part B to get the full benefits available from Medicare to cover certain dialysis and kidney transplant services.

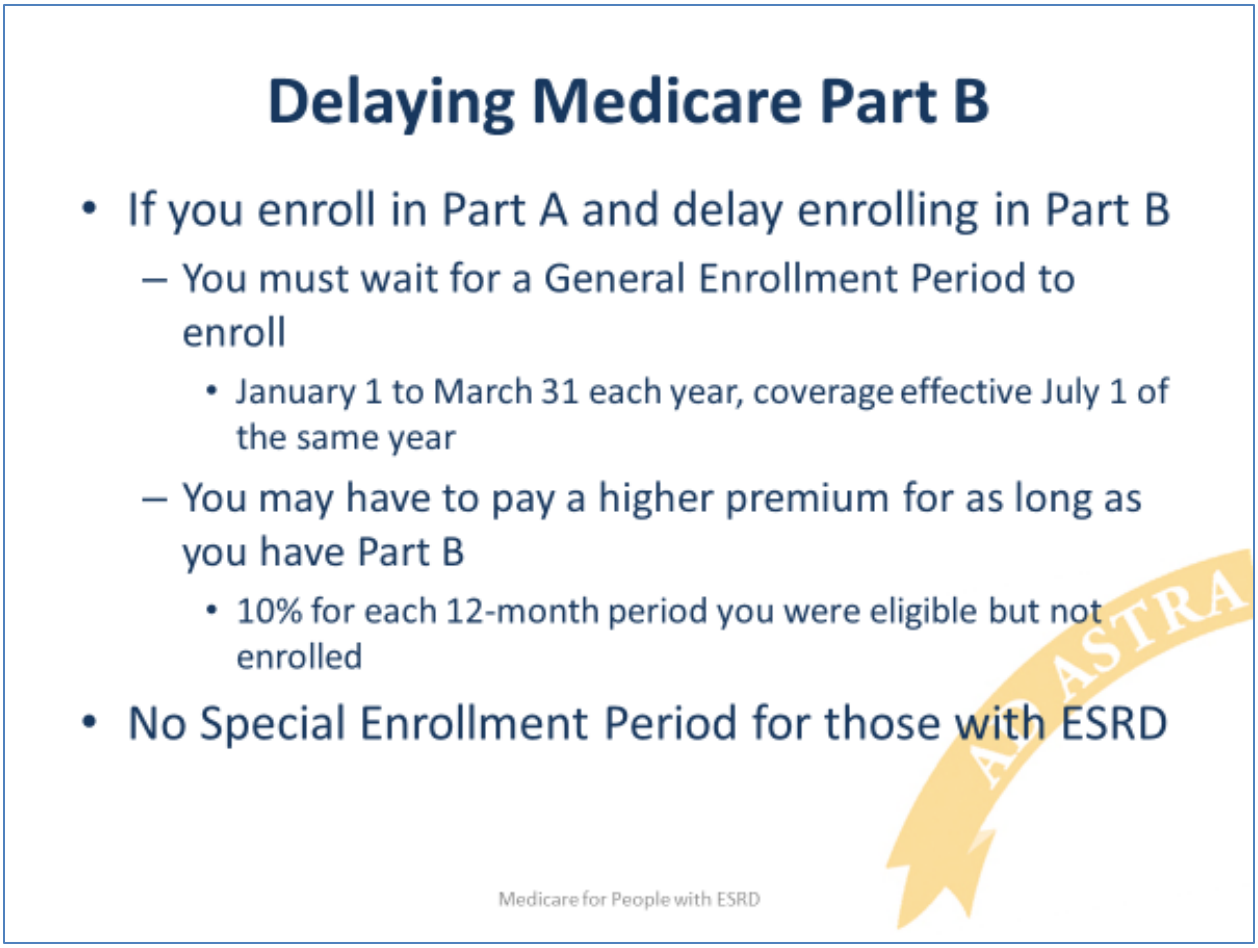
Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD, and for more information about the amount of work needed under Social Security or as a federal employee to be eligible for Medicare. You can contact Social Security at 1-800-772-1213. TTY: 1-800-325-0778. If you work or worked for a railroad, call the Railroad Retirement Board at 1-877-772-5772. TTY: 1-312-751-4701.

NOTE: If you don't qualify for Medicare, you may be able to get help from your state Medicaid agency to pay for your dialysis treatments. Your income must be below a certain level to receive Medicaid. In some states, if you have Medicare, Medicaid may pay some of the costs that Medicare doesn't cover. To apply for Medicaid, talk with the social worker at your hospital or dialysis facility, or contact your local Department of Human Services or Social Services.



If you're already enrolled in Medicare based on age or disability, and you're already paying a higher Part B premium because you didn't enroll in Part B when you were first eligible, you'll no longer have to pay the penalty when you become entitled to Medicare based on ESRD. You'll still have to pay the Part B premium. Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

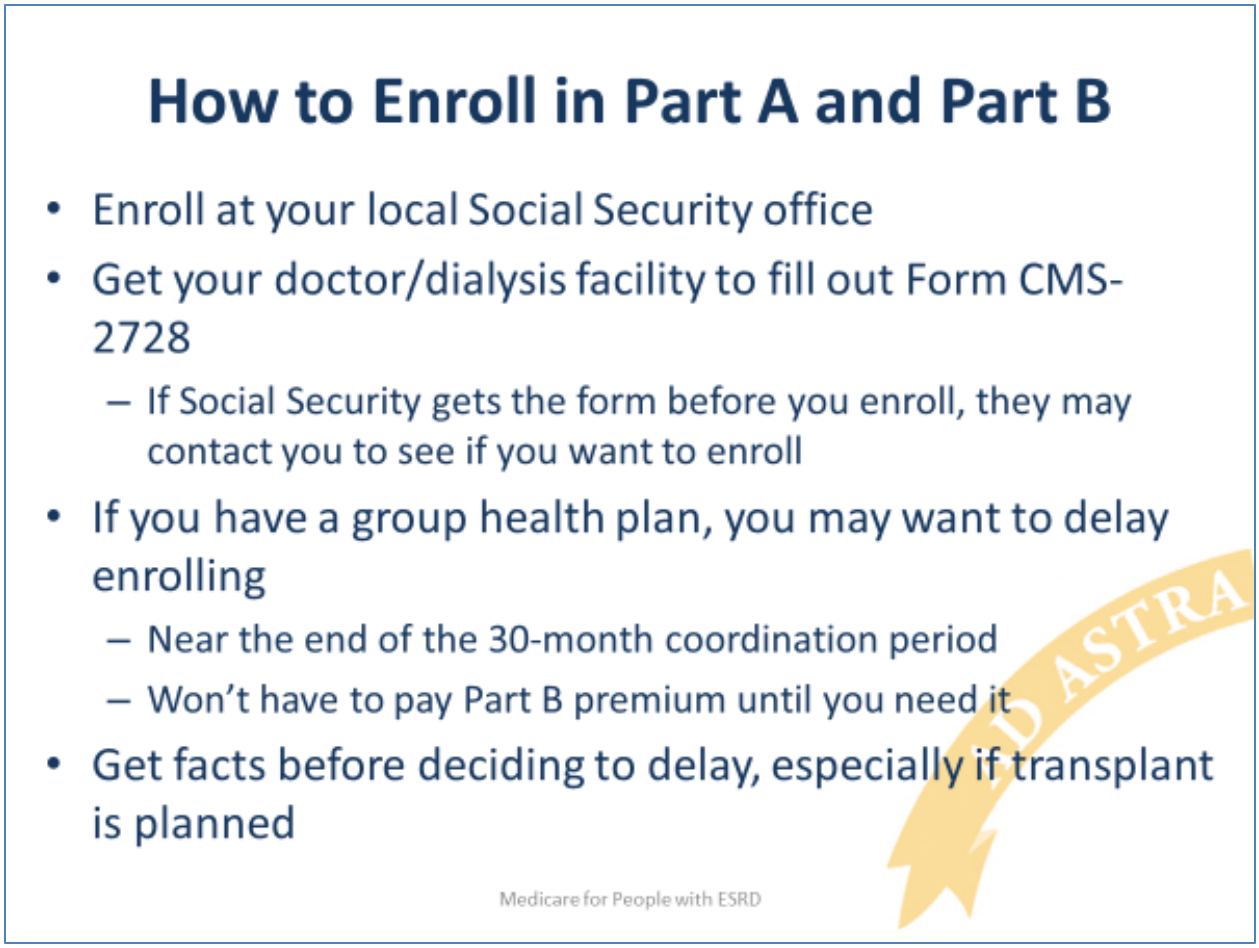
If you're receiving Medicare benefits based on ESRD when you turn 65, you have continuous coverage with no interruption. If you didn't have Part B prior to 65, you'll automatically be enrolled in Part B when you turn 65, but you can decide whether or not to keep it.



If you enroll in Part A and wait to enroll in Part B, you may have a gap in coverage since most expenses incurred for ESRD are covered by Part B rather than Part A. You'll only be able to enroll in Part B during a General Enrollment Period, January 1 to March 31 each year, with Part B coverage effective July 1 of the same year.

In addition, your Part B premium may be higher. This late enrollment penalty is 10% for each 12-month period you were eligible but not enrolled.

There's no Special Enrollment Period for Part B if you have ESRD. This includes individuals who are dually entitled to Medicare based on ESRD and age or disability. For more information, visit https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801247.

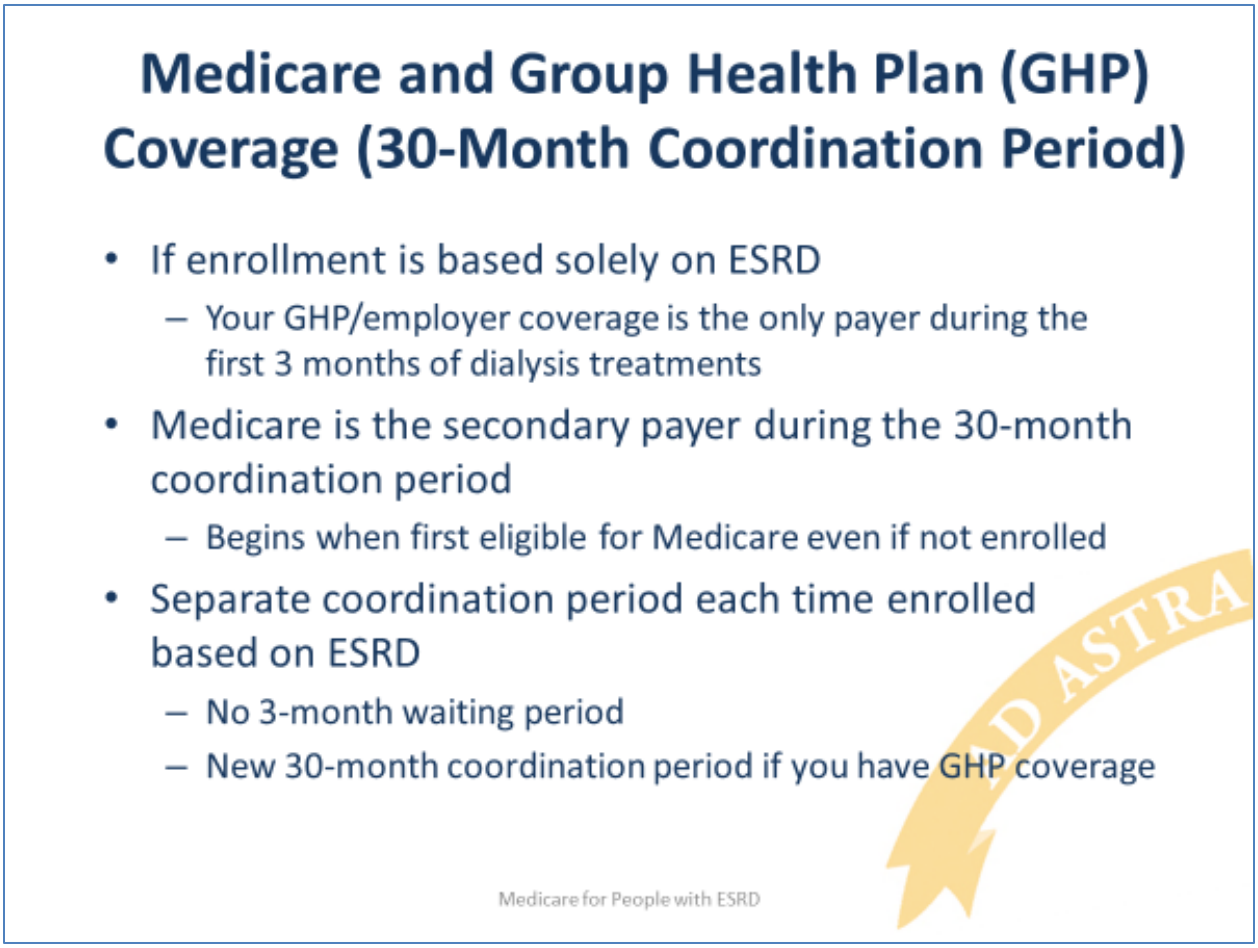


You can enroll in Medicare Part A and Part B based on ESRD at your local Social Security office. Social Security will need your doctor or the dialysis facility to complete Form CMS-2728 to document that you have ESRD and can get Medicare. If Form CMS-2728 is sent to Social Security before you apply, the office may contact you to ask if you want to complete an application.

Regardless of the number of employees and whether the coverage is based on current employment status, Medicare is the secondary payer of benefits for the first 30 months of Medicare eligibility (known as the 30-month coordination period) for people with ESRD who have an employer or union group health plan (GHP) coverage. If your GHP coverage will pay for most or all of your health care costs (for example, if it doesn't have a yearly deductible), you may want to delay enrolling in Part A and Part B until you're getting near to the end of the 30-month coordination period. If you delay enrollment, you won't have to pay the Part B premium for coverage you don't need yet. After the 30-month coordination period, you should enroll in Part A and Part B.

If you'll soon receive a kidney transplant, get the facts about eligibility and enrollment before deciding to delay because there are shorter time periods for eligibility and enrollment deadlines for transplant recipients (see slides 14–16).

Call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD. TTY: 1-800-325-0778.

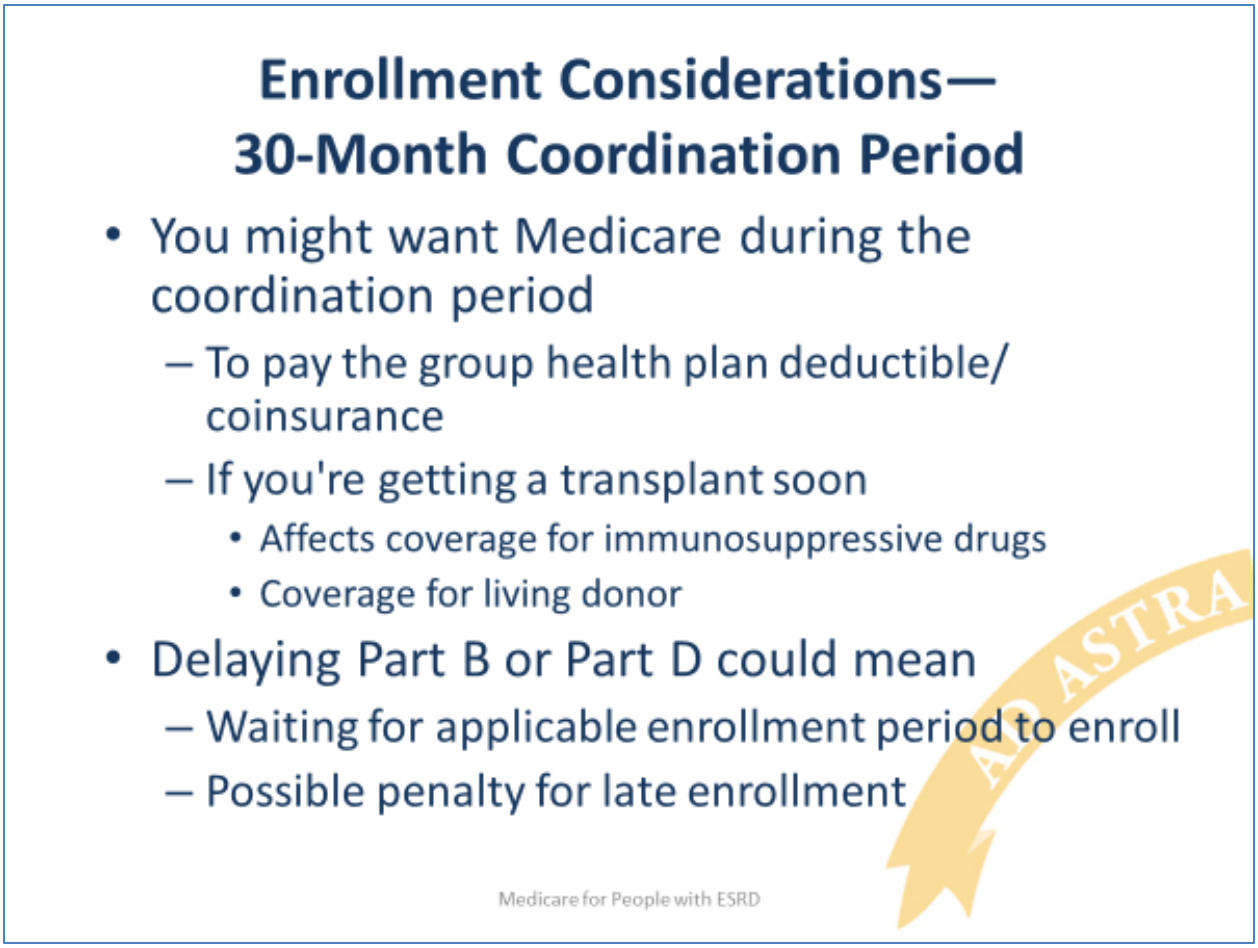


If you're eligible for Medicare because you get a regular course of dialysis treatments, your Medicare entitlement will usually start the fourth month of a regular course of dialysis. Therefore, Medicare generally won't pay anything during your first 3 months of a regular course of dialysis unless you already have Medicare because of age or disability. If you're covered by a group health plan (GHP), that plan is generally the only payer for the first 3 months of a regular course of dialysis.

Once you have Medicare coverage because of ESRD:

There's a period when your GHP will pay first on your health care bills, and Medicare will pay second. This period is called a 30-month coordination period. However, some Medicare plans sponsored by employers will pay first. Contact your plan's benefits administrator for more information.

- There's a separate 30-month coordination period each time you enroll in Medicare based on ESRD. For example, if you get a kidney transplant that functions for 36 months, your Medicare coverage will end. If after 36 months you enroll in Medicare again because you start dialysis or get another transplant, your Medicare coverage will start again right away. There will be no 3-month waiting period before Medicare begins to pay. However, there will be a new 30-month coordination period if you have GHP coverage.



The 30-month coordination period starts the first month you're able to get Medicare, even if you haven't signed up yet.

Example: You start dialysis in June. The 30-month coordination period generally starts September 1 (the fourth month of dialysis even if you don't have Medicare). Tell your providers if you have employer group health plan (EGHP) coverage during this period, so your services are billed correctly. After the 30-month coordination period, Medicare pays first for all Medicare-covered services. Your EGHP may pay for services not covered by Medicare. If you're covered by an EGHP, you may want to delay applying for Medicare. Here are some things to consider:

- If your EGHP pays all of your health care costs with no deductible or coinsurance, you may want to delay enrolling in Medicare until shortly before the 30-month coordination period ends to avoid a break in coverage. Many EGHPs will cut off primary payment after the 30th month. If you pay a deductible or coinsurance under your EGHP, enrolling in Medicare Part A and Part B could pay those costs.
- If you enroll in Part A, but delay Part B, you don't pay the Part B premium during this time. However, you'll have to wait until the next General Enrollment Period (January 1–March 31) to enroll (coverage effective July 1) and your premium may be higher.
- If you enroll in Part A, but delay Part D (Medicare Prescription Drug Coverage), you don't have to pay a Part D premium during this time. You may have to wait until the next Open Enrollment Period to enroll (from October 15–December 7, with coverage effective January 1) and you may have to pay a lifetime monthly late enrollment penalty if you don't have other creditable drug coverage (drug coverage that is expected to pay on average as much as standard Medicare prescription drug coverage).

Enrollment Considerations—Immunosuppressive Drugs

If You	Your Immunosuppressive Drugs
Are entitled to Part A at time of transplant **and** ▪ Medicare paid for your transplant and the transplant took place in a Medicare-approved facility, **or** ▪ Medicare was secondary payer but made no payment	Are covered by Part B ▪ Medicare pays 80% ▪ You pay 20% • Coinsurance costs don't count toward catastrophic coverage under Part D
Didn't meet the transplant conditions above	May be covered by Part D (unless you would be covered by Part B, if you had it) ▪ Costs vary by plan ▪ Helps cover drugs needed for other conditions

Medicare for People with ESRD

Immunosuppressive drug therapy is only covered by Medicare Part B for people who were entitled to Part A at the time of a kidney transplant, provided that

- The transplant was performed in a Medicare-approved facility, and
- Medicare made a payment for the transplant, or
- If Medicare made no payment, Medicare was the secondary payer

Medicare entitlement ends 36 months after a successful kidney transplant if ESRD is the only reason for Medicare entitlement, i.e., the person isn't 65 and doesn't get Social Security disability benefits. Enrolling in Part D (Medicare prescription drug coverage) doesn't change this period.

If Part B covers these drugs, and you have a Part D plan, the Part B coinsurance costs don't count toward your Part D catastrophic coverage (true out-of-pocket costs).

People who don't meet the conditions for Part B coverage of immunosuppressive drugs may be able to get coverage by enrolling in Part D. However, Part D won't cover immunosuppressive drugs if they would be covered by Part B, if the person had it. Part D could help pay for outpatient drugs needed to treat other medical conditions, such as high blood pressure, uncontrolled blood sugar, or high cholesterol.

When Medicare Coverage Starts Based on ESRD

Your Coverage Starts	Under the Following Circumstances
First day of the fourth month	You get a regular course of dialysis in a facility
First day of the month of the First month of dialysis	You participate in a home dialysis training program during the first 3 months of your regular course of dialysis (with expectation of completion)
First day of the month	You get a kidney transplant
First day of the month	You're admitted to a Medicare-approved transplant facility for a kidney transplant or procedures preliminary to a kidney transplant if transplant takes place in the same month or within the following 2 months
Two months before the month of your transplant	Your transplant is delayed more than 2 months after you're admitted to the hospital for the transplant **or** for health care services you need for the transplant

Medicare for People with ESRD

Medicare coverage usually begins on the first day of the fourth month of a regular course of dialysis. This initial 3-month period is called the qualifying period.

Coverage can begin the first month of a regular course of dialysis treatments if you meet all of these conditions:

- You participate in a home dialysis training program offered by a Medicare-approved training facility during the first 3 months of your regular course of dialysis
- Your doctor expects you to finish training and be able to do your own dialysis treatments

Medicare coverage begins the month you get a kidney transplant, or the month you're admitted to an approved hospital for a transplant or for procedures preliminary to a transplant, providing that the transplant takes place in that month or within the 2 following months.

Medicare coverage can start 2 months before the month of your transplant, if your transplant is delayed more than 2 months after you're admitted to the hospital for the transplant, **or** for health care services you need before your transplant.

NOTE: When you enroll in Medicare based on ESRD and you're on dialysis, Medicare coverage usually starts on the first day of the fourth month of your dialysis treatments. This waiting period will start even if you haven't signed up for Medicare. For example, if you don't sign up until after you've met all the requirements, your coverage could begin up to 12 months before the month you apply.

When Coverage for ESRD Ends, Continues, or Resumes

When Coverage Ends	When Coverage Continues	When Coverage Resumes
Entitlement based solely on ESRD • Coverage ends 12 months after the month you no longer require a regular course of dialysis, **or** • 36 months after the month of your kidney transplant	• No interruption in coverage if you start a regular course of dialysis again within 12 months after regular dialysis stopped, **or** • You have a kidney transplant, **or** • Regular course of dialysis starts within 36 months after transplant, **or** • You received another kidney transplant within 36 months	Must file new application and there's no waiting period if • You start a regular course of dialysis again or get a kidney transplant more than 12 months after you stopped getting a regular course of dialysis • You have another kidney transplant more than 36 months later

Medicare for People with ESRD

If you're eligible for Medicare coverage only because of ESRD, your Medicare coverage will end

- 12 months after the month you stop dialysis treatments, **or**
- 36 months after the month you have a kidney transplant

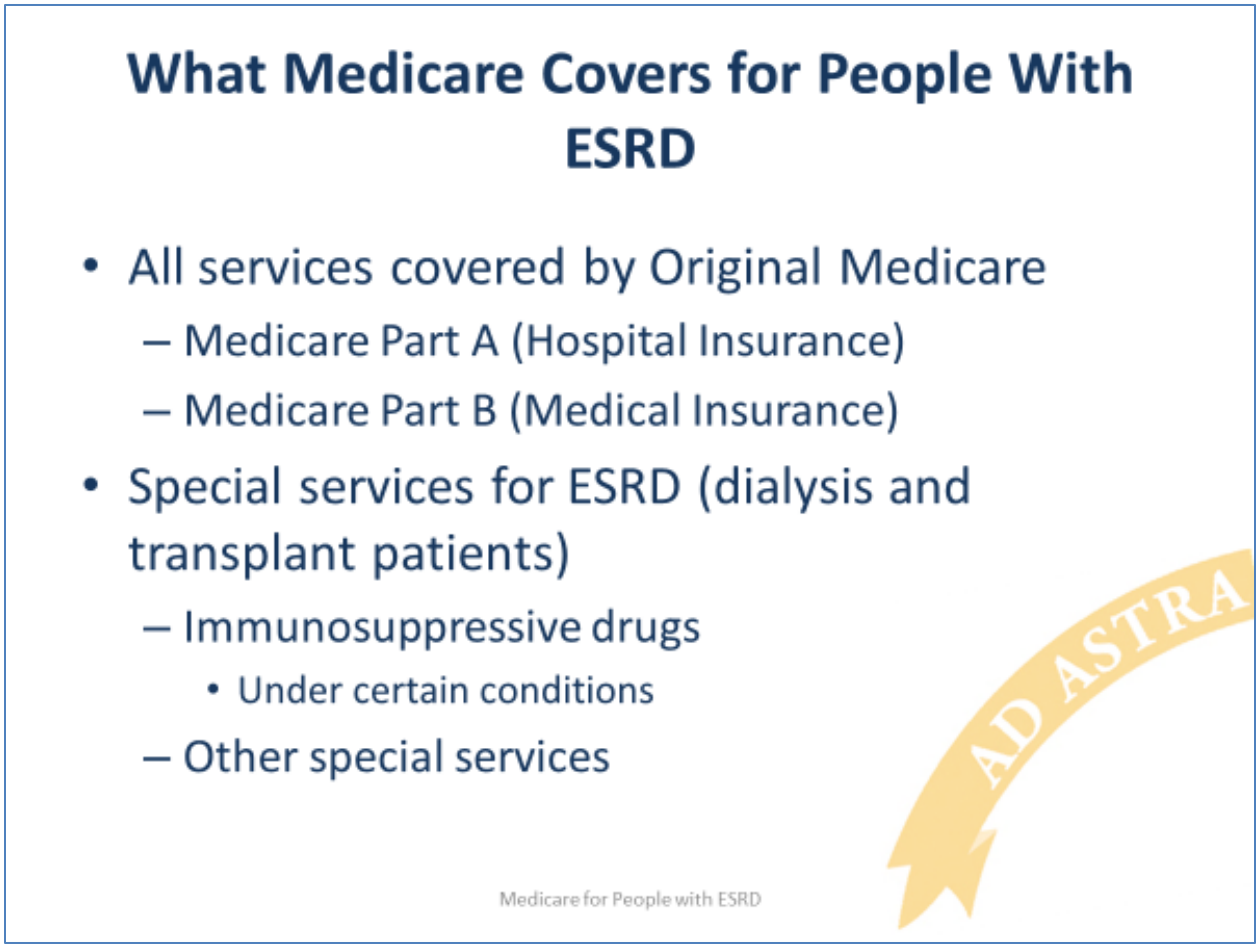
Medicare coverage will *continue* without interruption if

- You start a regular course of dialysis again or get a kidney transplant within 12 months after you stopped getting a regular course of dialysis, **or**
- You start a regular course of dialysis or get another kidney transplant before the end of the 36-month post-transplant period

Medicare coverage will *resume* with no waiting period if

- You start a regular course of dialysis again or get a kidney transplant more than 12 months after you stopped getting a regular course of dialysis, **or**
- You start a regular course of dialysis or get another kidney transplant more than 36 months after the month of a kidney transplant

NOTE: It's important to note that for coverage to resume, you must file a new application for this new period of Medicare entitlement (see process on slide 12).



As a person entitled to Medicare based on ESRD, you're entitled to all Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) services covered under Original Medicare. You may also choose to get the same prescription drug coverage (Part D) as any other person with Medicare.

In addition, special services are available for people with ESRD. These include coverage for immunosuppressive drugs for transplant patients, as long as certain conditions are met (described earlier), and other services for transplant and dialysis patients.

Visit Medicare.gov/coverage/dialysis-services-and-supplies.html for more information on covered services and supplies.

Course Completion

- Thank you for completing this pre-training course!
- You have reviewed the following:
  - Medicare Core Basics
  - Medicare Part A
  - Medicare Part B
  - Preventive Benefits
  - Medicare for People with Disabilities
  - Medicare for People with ESRD
- You should now follow the instructions on the next page to complete the course exam.

Please log into the SHIP Technical Assistance Center, https://www.shiptacenter.org/

Use the Online Counselor Certification Tool, https://shipta.medicareinteractive.org/ship-certification-tool, to complete the SHICK Initial Pre-Training Course 1 Exam.

In *Course 2 Introduction to Medicare Part C (Advantage), Medicare Part D, and Medigap*, you will cover Medicare Part C, Medicare Part D, and Medicare Supplement Insurance (Medigap)